

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12188

Reg. Dist. No.

12193

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 6402 Greig Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Milton Last Adams				4. DATE OF DEATH Month November Day 9 Year 1957			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-12-39		9. AGE (In years last birthday) 18 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk		10b. KIND OF BUSINESS OR INDUSTRY Drug Store		11. BIRTHPLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul B. Adams				14. MOTHER'S MAIDEN NAME Eleenor B. Glispie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Paul B. Adams; same as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture of facial bones and deep laceration DUE TO (c) of skin and underlying structures.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in an automobile in collision with a truck.					
20c. TIME OF INJURY Month, Day, Year Hour XX p. m. 11-9- 19 57		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Nr. Bowie Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John T. Maloney</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, RELIGIOUS RITUAL Transportation		22b. DATE THEREOF 11/10/57		22c. NAME OF CEMETERY OR CREMATORY Hartwell		22d. LOCATION (City, town, or county) (State) Georgia	
23. FUNERAL DIRECTOR'S SIGNATURE . Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE NOV 12 57	
				24b. REGISTRAR'S SIGNATURE <i>W. H. Smith</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John J. Smith		Male		45	
Date of Death		Place of Death		Cause of Death	
11-10-57		Home		Heart Disease	
Time of Death		Manner of Death		Signature of Examiner	
10:00 AM		Natural		J. A. Smith	
Signature of Physician		Signature of Coroner		Signature of Registrar	
J. A. Smith		J. A. Smith		J. A. Smith	

Signature of Medical Examiner and Registrar

Signature of Coroner and Registrar

Signature of Registrar and Coroner

BUREAU V. 2.

NOV 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12194

CERTIFICATE OF DEATH

12189

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>1 H 45 Min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X0 University Park</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				d. STREET ADDRESS <u>6704 Wells Parkway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Girl</u> <u>Adelstein</u>				4. DATE OF DEATH Month <u>November</u> Day <u>11</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 11, 57</u>		9. AGE (In years lost birthday) yrs. <u>1</u> <u>45</u>	10. IF UNDER 1 YEAR Months <u>1</u> Days <u>45</u>	11. IF UNDER 24 HRS. Hours <u>1</u> Min. <u>45</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Benjamin Adelstein</u>				14. MOTHER'S MAIDEN NAME <u>Bernice Moser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u>		Address <u>as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apnea</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pre-maturity</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/11/57</u> , <u>19 57</u> , to <u>11/11/</u> , <u>19 57</u> , that I last saw the deceased alive on <u>11/11/</u> , <u>19 57</u> , and that death occurred at <u>10:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John L. Haught</u> M.D.				ADDRESS (Street, city or town, state)		DATE SIGNED <u>11/13/57</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Haught</u>				<u>Mt. Rainier, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prince Georges General Hospital, Cheverly, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry W. Penn, Jr., Administrator</u>				24a. REC'D BY REGISTRAR <u>DEC 9 57</u>		24b. REGISTRAR'S SIGNATURE	

UREAU V. S.

DEC 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12252

CERTIFICATE OF DEATH

12190

Reg. Dist. No. 734

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs		c. LENGTH OF STAY IN 1b 65 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Camp Springs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6301--Allentown Rd., SE				d. STREET ADDRESS 6301--Allentown Rd., SE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGUERITE Middle B. Last ALLEN				4. DATE OF DEATH Month Nov. Day 4th Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1st, 1892		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Marshall				14. MOTHER'S MAIDEN NAME Ella Mae Duckett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Viola M. Patterson 6301--Allentown Rd., SE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X DUE TO PULMONARY EDEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CONGESTIVE HEART FAILURE (c) MITRAL STENOSIS INTERVAL BETWEEN ONSET AND DEATH 4 HOURS SEVERAL YEARS						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB. 1951, to NOVEMBER 3, 1957, that I last saw the deceased alive on NOVEMBER 2, 1957, and that death occurred at 12:20 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Alfred R. Lapin				ADDRESS (Street, city or town, state) Woodyard Rd., Clinton, Md. DATE SIGNED Nov. 4-57			
PHYSICIAN'S NAME (Type) Dr. Alfred R. Lapin				Woodyard Rd. Clinton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 11-6-57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Simon Bros				ADDRESS 1661--Good Hope Rd., SE Washington, DC		24a. REC'D BY REGISTRAR NOV 5 1957	
				24b. REGISTRAR'S SIGNATURE Carrie Campbell			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. BROWN		2. SEX MALE		3. AGE 45		4. DATE OF BIRTH 1912	
5. PLACE OF BIRTH NEW YORK		6. OCCUPATION LABORER		7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL	
9. PLACE OF DEATH HOME		10. DATE OF DEATH 1957		11. TIME OF DEATH 10:00 AM		12. SIGNATURE OF PHYSICIAN [Signature]	
13. SIGNATURE OF REGISTRAR [Signature]		14. SIGNATURE OF WITNESS [Signature]		15. SIGNATURE OF SECOND WITNESS [Signature]		16. SIGNATURE OF THIRD WITNESS [Signature]	
17. SIGNATURE OF FOURTH WITNESS [Signature]		18. SIGNATURE OF FIFTH WITNESS [Signature]		19. SIGNATURE OF SIXTH WITNESS [Signature]		20. SIGNATURE OF SEVENTH WITNESS [Signature]	
21. SIGNATURE OF EIGHTH WITNESS [Signature]		22. SIGNATURE OF NINTH WITNESS [Signature]		23. SIGNATURE OF TENTH WITNESS [Signature]		24. SIGNATURE OF ELEVENTH WITNESS [Signature]	
25. SIGNATURE OF TWELFTH WITNESS [Signature]		26. SIGNATURE OF THIRTEENTH WITNESS [Signature]		27. SIGNATURE OF FOURTEENTH WITNESS [Signature]		28. SIGNATURE OF FIFTEENTH WITNESS [Signature]	
29. SIGNATURE OF SIXTEENTH WITNESS [Signature]		30. SIGNATURE OF SEVENTEENTH WITNESS [Signature]		31. SIGNATURE OF EIGHTEENTH WITNESS [Signature]		32. SIGNATURE OF NINETEENTH WITNESS [Signature]	
33. SIGNATURE OF TWENTIETH WITNESS [Signature]		34. SIGNATURE OF TWENTY-FIRST WITNESS [Signature]		35. SIGNATURE OF TWENTY-SECOND WITNESS [Signature]		36. SIGNATURE OF TWENTY-THIRD WITNESS [Signature]	
37. SIGNATURE OF TWENTY-FOURTH WITNESS [Signature]		38. SIGNATURE OF TWENTY-FIFTH WITNESS [Signature]		39. SIGNATURE OF TWENTY-SIXTH WITNESS [Signature]		40. SIGNATURE OF TWENTY-SEVENTH WITNESS [Signature]	
41. SIGNATURE OF TWENTY-EIGHTH WITNESS [Signature]		42. SIGNATURE OF TWENTY-NINTH WITNESS [Signature]		43. SIGNATURE OF THIRTIETH WITNESS [Signature]		44. SIGNATURE OF THIRTY-FIRST WITNESS [Signature]	
45. SIGNATURE OF THIRTY-SECOND WITNESS [Signature]		46. SIGNATURE OF THIRTY-THIRD WITNESS [Signature]		47. SIGNATURE OF THIRTY-FOURTH WITNESS [Signature]		48. SIGNATURE OF THIRTY-FIFTH WITNESS [Signature]	
49. SIGNATURE OF THIRTY-SIXTH WITNESS [Signature]		50. SIGNATURE OF THIRTY-SEVENTH WITNESS [Signature]		51. SIGNATURE OF THIRTY-EIGHTH WITNESS [Signature]		52. SIGNATURE OF THIRTY-NINTH WITNESS [Signature]	
53. SIGNATURE OF FORTY WITNESS [Signature]		54. SIGNATURE OF FORTY-FIRST WITNESS [Signature]		55. SIGNATURE OF FORTY-SECOND WITNESS [Signature]		56. SIGNATURE OF FORTY-THIRD WITNESS [Signature]	
57. SIGNATURE OF FORTY-FOURTH WITNESS [Signature]		58. SIGNATURE OF FORTY-FIFTH WITNESS [Signature]		59. SIGNATURE OF FORTY-SIXTH WITNESS [Signature]		60. SIGNATURE OF FORTY-SEVENTH WITNESS [Signature]	
61. SIGNATURE OF FORTY-EIGHTH WITNESS [Signature]		62. SIGNATURE OF FORTY-NINTH WITNESS [Signature]		63. SIGNATURE OF FIFTIETH WITNESS [Signature]		64. SIGNATURE OF FIFTY-FIRST WITNESS [Signature]	
65. SIGNATURE OF FIFTY-SECOND WITNESS [Signature]		66. SIGNATURE OF FIFTY-THIRD WITNESS [Signature]		67. SIGNATURE OF FIFTY-FOURTH WITNESS [Signature]		68. SIGNATURE OF FIFTY-FIFTH WITNESS [Signature]	
69. SIGNATURE OF FIFTY-SIXTH WITNESS [Signature]		70. SIGNATURE OF FIFTY-SEVENTH WITNESS [Signature]		71. SIGNATURE OF FIFTY-EIGHTH WITNESS [Signature]		72. SIGNATURE OF FIFTY-NINTH WITNESS [Signature]	
73. SIGNATURE OF SIXTIETH WITNESS [Signature]		74. SIGNATURE OF SIXTY-FIRST WITNESS [Signature]		75. SIGNATURE OF SIXTY-SECOND WITNESS [Signature]		76. SIGNATURE OF SIXTY-THIRD WITNESS [Signature]	
77. SIGNATURE OF SIXTY-FOURTH WITNESS [Signature]		78. SIGNATURE OF SIXTY-FIFTH WITNESS [Signature]		79. SIGNATURE OF SIXTY-SIXTH WITNESS [Signature]		80. SIGNATURE OF SIXTY-SEVENTH WITNESS [Signature]	
81. SIGNATURE OF SIXTY-EIGHTH WITNESS [Signature]		82. SIGNATURE OF SIXTY-NINTH WITNESS [Signature]		83. SIGNATURE OF SEVENTIETH WITNESS [Signature]		84. SIGNATURE OF SEVENTY-FIRST WITNESS [Signature]	
85. SIGNATURE OF SEVENTY-SECOND WITNESS [Signature]		86. SIGNATURE OF SEVENTY-THIRD WITNESS [Signature]		87. SIGNATURE OF SEVENTY-FOURTH WITNESS [Signature]		88. SIGNATURE OF SEVENTY-FIFTH WITNESS [Signature]	
89. SIGNATURE OF SEVENTY-SIXTH WITNESS [Signature]		90. SIGNATURE OF SEVENTY-SEVENTH WITNESS [Signature]		91. SIGNATURE OF SEVENTY-EIGHTH WITNESS [Signature]		92. SIGNATURE OF SEVENTY-NINTH WITNESS [Signature]	
93. SIGNATURE OF EIGHTIETH WITNESS [Signature]		94. SIGNATURE OF EIGHTY-FIRST WITNESS [Signature]		95. SIGNATURE OF EIGHTY-SECOND WITNESS [Signature]		96. SIGNATURE OF EIGHTY-THIRD WITNESS [Signature]	
97. SIGNATURE OF EIGHTY-FOURTH WITNESS [Signature]		98. SIGNATURE OF EIGHTY-FIFTH WITNESS [Signature]		99. SIGNATURE OF EIGHTY-SIXTH WITNESS [Signature]		100. SIGNATURE OF EIGHTY-SEVENTH WITNESS [Signature]	
101. SIGNATURE OF EIGHTY-EIGHTH WITNESS [Signature]		102. SIGNATURE OF EIGHTY-NINTH WITNESS [Signature]		103. SIGNATURE OF NINETY WITNESS [Signature]		104. SIGNATURE OF NINETY-FIRST WITNESS [Signature]	
105. SIGNATURE OF NINETY-SECOND WITNESS [Signature]		106. SIGNATURE OF NINETY-THIRD WITNESS [Signature]		107. SIGNATURE OF NINETY-FOURTH WITNESS [Signature]		108. SIGNATURE OF NINETY-FIFTH WITNESS [Signature]	
109. SIGNATURE OF NINETY-SIXTH WITNESS [Signature]		110. SIGNATURE OF NINETY-SEVENTH WITNESS [Signature]		111. SIGNATURE OF NINETY-EIGHTH WITNESS [Signature]		112. SIGNATURE OF NINETY-NINTH WITNESS [Signature]	
113. SIGNATURE OF HUNDRED WITNESS [Signature]		114. SIGNATURE OF HUNDRED-FIRST WITNESS [Signature]		115. SIGNATURE OF HUNDRED-SECOND WITNESS [Signature]		116. SIGNATURE OF HUNDRED-THIRD WITNESS [Signature]	
117. SIGNATURE OF HUNDRED-FOURTH WITNESS [Signature]		118. SIGNATURE OF HUNDRED-FIFTH WITNESS [Signature]		119. SIGNATURE OF HUNDRED-SIXTH WITNESS [Signature]		120. SIGNATURE OF HUNDRED-SEVENTH WITNESS [Signature]	
121. SIGNATURE OF HUNDRED-EIGHTH WITNESS [Signature]		122. SIGNATURE OF HUNDRED-NINTH WITNESS [Signature]		123. SIGNATURE OF HUNDRED-TENTH WITNESS [Signature]		124. SIGNATURE OF HUNDRED-ELEVENTH WITNESS [Signature]	
125. SIGNATURE OF HUNDRED-TWELTH WITNESS [Signature]		126. SIGNATURE OF HUNDRED-THIRTEENTH WITNESS [Signature]		127. SIGNATURE OF HUNDRED-FOURTEENTH WITNESS [Signature]		128. SIGNATURE OF HUNDRED-FIFTEENTH WITNESS [Signature]	
129. SIGNATURE OF HUNDRED-SIXTEENTH WITNESS [Signature]		130. SIGNATURE OF HUNDRED-SEVENTEENTH WITNESS [Signature]		131. SIGNATURE OF HUNDRED-EIGHTEENTH WITNESS [Signature]		132. SIGNATURE OF HUNDRED-NINETEENTH WITNESS [Signature]	
133. SIGNATURE OF HUNDRED-TWENTIETH WITNESS [Signature]		134. SIGNATURE OF HUNDRED-TWENTY-FIRST WITNESS [Signature]		135. SIGNATURE OF HUNDRED-TWENTY-SECOND WITNESS [Signature]		136. SIGNATURE OF HUNDRED-TWENTY-THIRD WITNESS [Signature]	
137. SIGNATURE OF HUNDRED-TWENTY-FOURTH WITNESS [Signature]		138. SIGNATURE OF HUNDRED-TWENTY-FIFTH WITNESS [Signature]		139. SIGNATURE OF HUNDRED-TWENTY-SIXTH WITNESS [Signature]		140. SIGNATURE OF HUNDRED-TWENTY-SEVENTH WITNESS [Signature]	
141. SIGNATURE OF HUNDRED-TWENTY-EIGHTH WITNESS [Signature]		142. SIGNATURE OF HUNDRED-TWENTY-NINTH WITNESS [Signature]		143. SIGNATURE OF HUNDRED-THIRTIETH WITNESS [Signature]		144. SIGNATURE OF HUNDRED-THIRTY-FIRST WITNESS [Signature]	
145. SIGNATURE OF HUNDRED-THIRTY-SECOND WITNESS [Signature]		146. SIGNATURE OF HUNDRED-THIRTY-THIRD WITNESS [Signature]		147. SIGNATURE OF HUNDRED-THIRTY-FOURTH WITNESS [Signature]		148. SIGNATURE OF HUNDRED-THIRTY-FIFTH WITNESS [Signature]	
149. SIGNATURE OF HUNDRED-THIRTY-SIXTH WITNESS [Signature]		150. SIGNATURE OF HUNDRED-THIRTY-SEVENTH WITNESS [Signature]		151. SIGNATURE OF HUNDRED-THIRTY-EIGHTH WITNESS [Signature]		152. SIGNATURE OF HUNDRED-THIRTY-NINTH WITNESS [Signature]	
153. SIGNATURE OF HUNDRED-THIRTIETH WITNESS [Signature]		154. SIGNATURE OF HUNDRED-THIRTY-ONE WITNESS [Signature]		155. SIGNATURE OF HUNDRED-THIRTY-TWO WITNESS [Signature]		156. SIGNATURE OF HUNDRED-THIRTY-THREE WITNESS [Signature]	
157. SIGNATURE OF HUNDRED-THIRTY-FOUR WITNESS [Signature]		158. SIGNATURE OF HUNDRED-THIRTY-FIVE WITNESS [Signature]		159. SIGNATURE OF HUNDRED-THIRTY-SIX WITNESS [Signature]		160. SIGNATURE OF HUNDRED-THIRTY-SEVEN WITNESS [Signature]	
161. SIGNATURE OF HUNDRED-THIRTY-EIGHT WITNESS [Signature]		162. SIGNATURE OF HUNDRED-THIRTY-NINE WITNESS [Signature]		163. SIGNATURE OF HUNDRED-THIRTY WITNESS [Signature]		164. SIGNATURE OF HUNDRED-THIRTY-ONE WITNESS [Signature]	
165. SIGNATURE OF HUNDRED-THIRTY-TWO WITNESS [Signature]		166. SIGNATURE OF HUNDRED-THIRTY-THREE WITNESS [Signature]		167. SIGNATURE OF HUNDRED-THIRTY-FOUR WITNESS [Signature]		168. SIGNATURE OF HUNDRED-THIRTY-FIVE WITNESS [Signature]	
169. SIGNATURE OF HUNDRED-THIRTY-SIX WITNESS [Signature]		170. SIGNATURE OF HUNDRED-THIRTY-SEVEN WITNESS [Signature]		171. SIGNATURE OF HUNDRED-THIRTY-EIGHT WITNESS [Signature]		172. SIGNATURE OF HUNDRED-THIRTY-NINE WITNESS [Signature]	
173. SIGNATURE OF HUNDRED-THIRTY WITNESS [Signature]		174. SIGNATURE OF HUNDRED-THIRTY-ONE WITNESS [Signature]		175. SIGNATURE OF HUNDRED-THIRTY-TWO WITNESS [Signature]		176. SIGNATURE OF HUNDRED-THIRTY-THREE WITNESS [Signature]	
177. SIGNATURE OF HUNDRED-THIRTY-FOUR WITNESS [Signature]		178. SIGNATURE OF HUNDRED-THIRTY-FIVE WITNESS [Signature]		179. SIGNATURE OF HUNDRED-THIRTY-SIX WITNESS [Signature]		180. SIGNATURE OF HUNDRED-THIRTY-SEVEN WITNESS [Signature]	
181. SIGNATURE OF HUNDRED-THIRTY-EIGHT WITNESS [Signature]		182. SIGNATURE OF HUNDRED-THIRTY-NINE WITNESS [Signature]		183. SIGNATURE OF HUNDRED-THIRTY WITNESS [Signature]		184. SIGNATURE OF HUNDRED-THIRTY-ONE WITNESS [Signature]	
185. SIGNATURE OF HUNDRED-THIRTY-TWO WITNESS [Signature]		186. SIGNATURE OF HUNDRED-THIRTY-THREE WITNESS [Signature]		187. SIGNATURE OF HUNDRED-THIRTY-FOUR WITNESS [Signature]		188. SIGNATURE OF HUNDRED-THIRTY-FIVE WITNESS [Signature]	
189. SIGNATURE OF HUNDRED-THIRTY-SIX WITNESS [Signature]		190. SIGNATURE OF HUNDRED-THIRTY-SEVEN WITNESS [Signature]		191. SIGNATURE OF HUNDRED-THIRTY-EIGHT WITNESS [Signature]		192. SIGNATURE OF HUNDRED-THIRTY-NINE WITNESS [Signature]	
193. SIGNATURE OF HUNDRED-THIRTY WITNESS [Signature]		194. SIGNATURE OF HUNDRED-THIRTY-ONE WITNESS [Signature]		195. SIGNATURE OF HUNDRED-THIRTY-TWO WITNESS [Signature]		196. SIGNATURE OF HUNDRED-THIRTY-THREE WITNESS [Signature]	
197. SIGNATURE OF HUNDRED-THIRTY-FOUR WITNESS [Signature]		198. SIGNATURE OF HUNDRED-THIRTY-FIVE WITNESS [Signature]		199. SIGNATURE OF HUNDRED-THIRTY-SIX WITNESS [Signature]		200. SIGNATURE OF HUNDRED-THIRTY-SEVEN WITNESS [Signature]	

BUREAU V. 8

NOV 5 1957

RECEIVED

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12195 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12191
7/5

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 15 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 8200 Adelphi Road	
3. NAME OF DECEASED (Type or print) Irene Gertrude Angellier		4. DATE OF DEATH November 7, 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-13-90
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John Schleigh		14. MOTHER'S MAIDEN NAME Kate Morgan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 2-3 minutes after operation 584x DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic heart disease (c) Cholecystitis and choledocholithiasis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH ? years 20 years			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John J. Maloney M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> November 7, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/11/57	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Prince George County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS Silver Spring, Md.	
24a. REC'D BY REGISTRAR NOV 12 1957		24b. REGISTRAR'S SIGNATURE James L. ...	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, for its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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NOV 12 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12192

12196

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND Prince Georges				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Suitland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle E Last Austin				4. DATE OF DEATH Month November Day 22 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 7-11-21	
9. AGE (In years last birthday) 36 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Birmingham, Alabama	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Archie L Austin				14. MOTHER'S MAIDEN NAME Mary Ann Mosley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W. 2		17. INFORMANT Mary Ann Austin-Suitland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive left subdural hemorrhage 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerosis DUE TO (c) 3 DAYS INTERVAL BETWEEN ONSET AND DEATH YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) HYATTSVILLE, MD.				20g. (County) PRINCE GEORGES		20h. (State) MARYLAND	
21. I certify that I attended the deceased from 11/21 , 19 57 , to 11/22 , 19 57 ; that I last saw the deceased alive on 11/22 , 19 57 , and that death occurred at 6:30P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 905 SHEERIDAY ST. HYATTSVILLE, MD. DATE SIGNED 11/23/57							
ACTUAL SIGNATURE Henry R. Wolfe				M.D. 905 SHEERIDAY ST. HYATTSVILLE, MD.			
PHYSICIAN'S NAME (Type) Dr. Henry Wolfe							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-27-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Turner Home				ADDRESS Washington D.C.		24a. REC'D BY REGISTRAR NOV 26 '57	
				24b. REGISTRAR'S SIGNATURE W. Deane			

CERTIFICATE OF DEATH

ILLINOIS STATE DEPARTMENT OF HEALTH

Form No. 1

BUREAU V. S.

NOV 27 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12197 CERTIFICATE OF DEATH

12193
Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>Prince Geo.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Prince Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale, Md. 25</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Leland Memorial</u>				d. STREET ADDRESS <u>5018 Sheridan St</u>			
3. NAME OF DECEASED (Type or print) <u>Lillie M. Baker</u> First Middle Last				4. DATE OF DEATH <u>11</u> Month <u>12</u> Day <u>19</u> Year <u>57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-22-1880</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>20</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Elie Isett</u>			14. MOTHER'S MAIDEN NAME <u>Mary McMullen</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Record Office - 4408 Queensberry Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis generalized</u> DUE TO (c) <u>Hypertensive vascular disease</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	Month <u>11</u>	Day <u>12</u>	Year <u>1957</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-29</u> , <u>1957</u> , to <u>11-12</u> , <u>1957</u> , that I last saw the deceased alive on <u>11-12</u> , <u>1957</u> , and that death occurred at <u>7</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4408 Queensberry Rd. Riverdale, Md.</u> DATE SIGNED <u>D. R. Purdie</u>							
ACTUAL SIGNATURE <u>D. R. Purdie</u>				M.D. <u>4408 Queensberry Rd. Riverdale, Md.</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Transportation</u>		<u>11/13/57.</u>		<u>Royersford</u>		<u>Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Pachosano</u>				ADDRESS <u>4739 Balt. Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>15 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>James E. Severe</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 15 1957

RECEIVED

12253 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

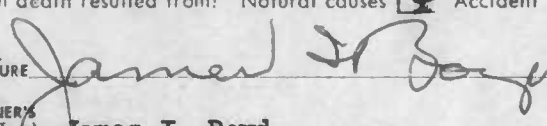
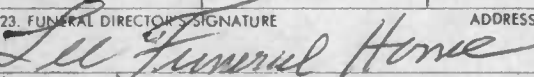
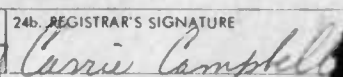
Reg. Dist. No.

FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 will be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, and its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 2/57

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville c. LENGTH OF STAY IN 1b T^hansient d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8200 Marlboro Pike S.E.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton d. STREET ADDRESS Route # 1 Box 742 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Chester Middle Earl Last Barnes		4. DATE OF DEATH Month November Day 4 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 6, 1893
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	11. BIRTHPLACE (State or foreign country) Michigan
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Thomas W. Barnes		14. MOTHER'S MAIDEN NAME Nellie Keller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 578 07 0619	17. INFORMANT Chester E. Barnes Jr.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m.	Month, Day, Year _____ 19 _____	20d. KIND OF INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) 		(County) 	
(State) 			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE 		DATE SIGNED November 5, 1957	
EXAMINER'S NAME (Type) James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-7-57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS Wash. D.C.	
24a. REC'D BY REGISTRAR NOV 6 1957		24b. REGISTRAR'S SIGNATURE 	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
 HEALTH DEPT.

Name of Deceased		Age		Sex		Race	
James W. Jones		45		Male		White	
Date of Death		Place of Death		Cause of Death		Manner of Death	
Oct. 6, 1957		Home		Heart Failure		Natural	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	
City		County		State		Zip	
Boston		Suffolk		Massachusetts		02108	

RECEIVED
 NOV 6 1957
 BUREAU V. 3

12254

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie, Maryland				c. LENGTH OF STAY IN 1b 21 years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie, Maryland				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bowie Race Track Road (rural)			
d. STREET ADDRESS Bowie Race Track Road (rural)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Howard Middle Eugene Last Beall				4. DATE OF DEATH Month November Day 18 , Year 19 57.			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 1884	9. AGE (In years last birthday) yrs. 73	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Tobacco		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Frank Beall				14. MOTHER'S MAIDEN NAME Alice L. Devaughn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212 30 0539		17. INFORMANT Beatrice Beall Address Bowie, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Cancer of Prostate DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3-4 mos 1 year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. 19	Month 19	Day 19	Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1 , 19 57 , to Nov 18 , 19 57 , that I last saw the deceased alive on Nov 18 , 19 57 , and that death occurred at 11:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert S Mc Ceney M.D.				ADDRESS (Street, city or town, state) 402 MAIN ST. LAUREL, MD.		DATE SIGNED 11/18/57	
PHYSICIAN'S NAME (Type) Ronert S Mc Ceney							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov 21, 1957	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				23b. REC'D BY REGISTRAR NOV 22 1957		24b. REGISTRAR'S SIGNATURE Mrs. J. W. Youngling	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED Doris Mae French		SEX Female		AGE 31 Years		DATE OF BIRTH November 11, 1907	
PLACE OF BIRTH Doris, Maryland		RACE White		RELIGION Roman Catholic		EDUCATION High School	
MARRIAGE Married		SPOUSE John French		DATE OF MARRIAGE June 1, 1928		PLACE OF MARRIAGE Doris, Maryland	
OCCUPATION Housewife		CAUSE OF DEATH Heart Disease		PERIOD OF ILLNESS Several Weeks		PLACE OF DEATH Home	
DATE OF DEATH November 11, 1937		TIME OF DEATH 10:30 AM		PLACE OF DEATH Home		SIGNATURE OF DECEASED (None)	
SIGNATURE OF PHYSICIAN J. H. Smith		DATE November 12, 1937		PLACE Doris, Maryland		SIGNATURE OF WITNESS (None)	
SIGNATURE OF CORONER J. H. Smith		DATE November 12, 1937		PLACE Doris, Maryland		SIGNATURE OF WITNESS (None)	

BUREAU V. 3

NOV 22 1937

RECEIVED

CERTIFICATE OF DEATH

1188

REG. NO. 1188

<p>1. NAME OF DECEASED 2. SEX 3. AGE 4. DATE OF BIRTH 5. PLACE OF BIRTH 6. OCCUPATION 7. MARITAL STATUS 8. COLOR OF SKIN 9. HIGHEST SCHOOLING 10. RELIGION 11. US. CITIZENSHIP 12. PLACE OF DEATH 13. DATE OF DEATH 14. TIME OF DEATH 15. CAUSE OF DEATH 16. MANNER OF DEATH 17. PLACE OF BURIAL 18. DATE OF BURIAL 19. NAME OF BURIAL PLACE 20. NAME OF MINISTER 21. NAME OF CLERGYMAN 22. NAME OF FUNERAL HOME 23. NAME OF UNDERTAKER 24. NAME OF CEMETERY 25. NAME OF INTERMENT</p>		<p>26. NAME OF PHYSICIAN 27. NAME OF SURGEON 28. NAME OF PATHOLOGIST 29. NAME OF ANATOMIST 30. NAME OF ENTOMOLOGIST 31. NAME OF FORENSIC SCIENTIST 32. NAME OF TOXICOLOGIST 33. NAME OF BACTERIOLOGIST 34. NAME OF VIROLOGIST 35. NAME OF IMMUNOLOGIST 36. NAME OF EPIDEMIOLOGIST 37. NAME OF STATISTICIAN 38. NAME OF PUBLIC HEALTH OFFICER 39. NAME OF HEALTH INSPECTOR 40. NAME OF NURSE 41. NAME OF DENTIST 42. NAME OF OPTICIAN 43. NAME OF PHARMACEUTICIAN 44. NAME OF VETERINARIAN 45. NAME OF AGRICULTURIST 46. NAME OF FISHERMAN 47. NAME OF MINER 48. NAME OF MANUFACTURER 49. NAME OF MERCHANT 50. NAME OF PROFESSIONAL MAN 51. NAME OF LABORER 52. NAME OF UNEMPLOYED PERSON 53. NAME OF OTHER PERSON</p>
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BUREAU V. S.

NOV 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12199

CERTIFICATE OF DEATH

12197

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b D O A			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Geroges General Hospital				e. STREET ADDRESS 4014 Bladensburg Rd			
3. NAME OF DECEASED (Type or print) First Charles Middle E Last Bell				4. DATE OF DEATH Month Nov Day 9 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 April 1882	9. AGE (In years for birthday) yrs. 75	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Navy Yard		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Bell				14. MOTHER'S MAIDEN NAME Amanda Gosnell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Ida F. Bell Cottage City Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension - (c) Arterio scleriosis						INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. n. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 11-5 , 19 57 , to 11-9 , 19 57 , that I last saw the deceased alive on 11-9 , 19 57 , and that death occurred at 1:40 A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Louis M. Jimal M.D. 7005 Bladensburg Rd PHYSICIAN'S NAME (Type) Louis M Jimal Cottage City, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 11, 1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis Marchisano				ADDRESS 4739 Balto Ave Hyatts, Md.		24a. REC'D BY REGISTRAR DATE NOV 12 '57	
				24b. REGISTRAR'S SIGNATURE Over			

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12198

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Branchville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. STREET ADDRESS 5408 Branchville Road	
3. NAME OF DECEASED (Type or print) Clifton Smith Boteler		4. DATE OF DEATH Month Nov. Day 18, Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1876
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired pressman		10b. KIND OF BUSINESS OR INDUSTRY Printing	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lemuel I. Boteler		14. MOTHER'S MAIDEN NAME Mary Moore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Elsie Huffer; 4606 Oliver St., Riverdale, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 812x DUE TO Conditions, if any, which gave rise to immediate cause (b) Multiple fractures of pelvis (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. A pedestrian, struck by an automobile. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 2.05 p.m. 11-18- 19 57 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 20f. (City or town) (County) (State) Berwyn Heights, Pr. Geo. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED November 18, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/21/1957	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE NOV 26 '57	
24b. REGISTRAR'S SIGNATURE Al Leach			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND
 DEPARTMENT OF HEALTH

NAME	George J. [illegible]
RESIDENCE	[illegible]
DATE OF BIRTH	[illegible]
DATE OF DEATH	[illegible]
PLACE OF DEATH	[illegible]
CAUSE OF DEATH	[illegible]
DIAGNOSIS	[illegible]
SEX	Male
RACE	White
RELIGION	[illegible]
EDUCATION	[illegible]
OCCUPATION	[illegible]
PREVIOUS ILLNESS	[illegible]
PREVIOUS SURGERY	[illegible]
PREVIOUS TRAUMA	[illegible]
PREVIOUS DRUGS	[illegible]
PREVIOUS ALCOHOL	[illegible]
PREVIOUS TOBACCO	[illegible]
PREVIOUS OTHER	[illegible]

Microscopic structure of pelvis
 Resembling and thick

peritonitis, attack by an amoeboma.

BUREAU V. 51

NOV 26 1957

RECEIVED

12201

CERTIFICATE OF DEATH

12199

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pr. George Co. Gen. Hospital				c. LENGTH OF STAY IN 1b 2 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pr. George Co. Gen. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ALICE M BRADY				4. DATE OF DEATH Month Day Year November 8, 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 13, 1881	
9. AGE (In years last birthday) yrs. 76		IF UNDER 1 YEAR Months Days Hours Min. 76		IF UNDER 24 HRS. Months Days Hours Min. 76			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Thomas M. Shorter				14. MOTHER'S MAIDEN NAME Mary Virginia Morgan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. ---			
17. INFORMANT Zadoc M. Brady, MD				Address 5534 Parkland Court, Parkland Village, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage 442X DUE TO (b) due to Hypertension CVA Disease? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) ---							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct 25, 19 57 to Nov 8, 19 57 , that I last saw the deceased alive on Nov 8, 19 57 , and that death occurred at 3:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) --- DATE SIGNED 11/8/57							
ACTUAL SIGNATURE William Brainin M.D.							
PHYSICIAN'S NAME (Type) Dr. William Brainin				6124 Central Avenue Cap. Hgt's., Md.			
22a. BURIAL, CREMATION, REMOVAL, (Specify) Burial				22b. DATE THEREOF 11/11/57		22c. NAME OF CEMETERY OR CREMATORY Epiphany Ch. Cemetery	
22d. LOCATION (City, town, or county) (State) Forrestville, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc.				24a. REC'D BY REGISTRAR NOV 12 '57		24b. REGISTRAR'S SIGNATURE Alfred Smith	

MEDICAL CERTIFICATION

BUREAU V. S.

NOV 12 1957

RECEIVED

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>Nov 21 1957</i>		6. TIME OF DEATH <i>10:30 AM</i>	
7. PLACE OF DEATH <i>Home</i>		8. CAUSE OF DEATH <i>Heart Disease</i>	
9. DISEASE OR INJURY <i>Myocardial Infarction</i>		10. MANNER OF DEATH <i>Natural</i>	
11. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		12. SIGNATURE OF REGISTRAR <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>	
15. SIGNATURE OF WITNESS <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>	
17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. SIGNATURE OF WITNESS <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>	
23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>	
27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>	
29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>	
33. SIGNATURE OF WITNESS <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>	
35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>	
39. SIGNATURE OF WITNESS <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Doe</i>	
41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>	
45. SIGNATURE OF WITNESS <i>John Doe</i>		46. SIGNATURE OF WITNESS <i>John Doe</i>	
47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>	
51. SIGNATURE OF WITNESS <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>	
53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>	
57. SIGNATURE OF WITNESS <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>John Doe</i>	
59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>	
63. SIGNATURE OF WITNESS <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>	
65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>	
69. SIGNATURE OF WITNESS <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>	
71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>	
75. SIGNATURE OF WITNESS <i>John Doe</i>		76. SIGNATURE OF WITNESS <i>John Doe</i>	
77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>	
81. SIGNATURE OF WITNESS <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>	
83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>	
87. SIGNATURE OF WITNESS <i>John Doe</i>		88. SIGNATURE OF WITNESS <i>John Doe</i>	
89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>	
93. SIGNATURE OF WITNESS <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>	
95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>	
99. SIGNATURE OF WITNESS <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	

RECEIVED
NOV 21 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12203

CERTIFICATE OF DEATH

Reg. Dist. No. 12201

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 13 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Glen Middle D. Last Brown				4. DATE OF DEATH Month 11-8- Day 15 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. B. DATE OF BIRTH April 3, 1891	
9. AGE (In years last birthday) yrs. 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Head of Ind Education		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Grant Brown				14. MOTHER'S MAIDEN NAME Dellia Stack			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 0		17. INFORMANT Address Mrs. Suzette L. Brown College Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1 day (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes Mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 1957 to November 1957 , that I last saw the deceased alive on Nov 7, 1957 , and that death occurred at 5:45 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Etienne M.D.				DATE SIGNED 11-8-57			
PHYSICIAN'S NAME (Type) Dr. Etienne				ADDRESS (Street, city or town, state) College Park, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/11/57		22c. NAME OF CEMETERY OR CREMATORY National Memorial Park		22d. LOCATION (City, town, or county) (State) Falls Church Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Francis Maschio Sons				ADDRESS 4739 Baltimore Ave Hyattsville, Md		24a. REC'D BY REGISTRAR NOV 12 57	
				24b. REGISTRAR'S SIGNATURE Carbenaich			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1912		New York City		Natural		Heart Disease		Home		10:30 AM		J. Smith		A. Jones	
Occupation		Marital Status		Education		Religion		Usual Residence		Usual Occupation		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Teacher		Married		High School		Catholic		123 Main St		Teacher		Jan 15, 1957		10:30 AM		Home		J. Smith		A. Jones	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death	
Jan 15, 1957		10:30 AM		Home		J. Smith		A. Jones		Jan 15, 1957		10:30 AM		Home		J. Smith		A. Jones		Jan 15, 1957	
Cause of Death		Manner of Death		Place of Death		Signature of Physician		Signature of Registrar		Cause of Death		Manner of Death		Place of Death		Signature of Physician		Signature of Registrar		Cause of Death	
Heart Disease		Natural		Home		J. Smith		A. Jones		Heart Disease		Natural		Home		J. Smith		A. Jones		Heart Disease	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death	
Jan 15, 1957		10:30 AM		Home		J. Smith		A. Jones		Jan 15, 1957		10:30 AM		Home		J. Smith		A. Jones		Jan 15, 1957	
Cause of Death		Manner of Death		Place of Death		Signature of Physician		Signature of Registrar		Cause of Death		Manner of Death		Place of Death		Signature of Physician		Signature of Registrar		Cause of Death	
Heart Disease		Natural		Home		J. Smith		A. Jones		Heart Disease		Natural		Home		J. Smith		A. Jones		Heart Disease	

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NOV 12 1957
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12204

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>11 Da 5 Hrs 15 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville 15</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's General</u>				d. STREET ADDRESS <u>6213 Carlton Terrace</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARGARET BRUNETT</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>3</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 16, 1890</u>		9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>George R Brewington</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Acres Shaw</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hospital records Cheverly, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA - Coma</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Hypertensive Cardio Vascular Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 1/2 days</u> <u>5 1/2</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 1954, to <u>Nov 3</u> , 1957, that I last saw the deceased alive on <u>Nov 3</u> , 1957, and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gordon W Kelley</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>M.D. 6124-41st Ave. Hyattsville, Md 11/4/57</u>			
PHYSICIAN'S NAME (Type) <u>Gordon W. Kelley</u>				<u>Hyattsville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 6, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 7 '57</u>	
						24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Lanham			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS Rt2 Box 297 Riverdale Rd.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Shawn		First Shawn		Middle Burke		Last Burke	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-20-53	
9. AGE (In years last birthday) 4 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter Burke				14. MOTHER'S MAIDEN NAME Lorraine Hartner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) ---		17. INFORMANT Mrs. Walter Burke, Lanham Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Palmar edema DUE TO 481X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Cardiac failure DUE TO seconds (c) Convulsion due to increased intracranial pressure 2 hrs.		INTERVAL BETWEEN ONSET AND DEATH seconds					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Vomiting - pernicious - viral origin? Asian flu		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-20-57 19 57 , to 11-20-57 , 19 57 , that I last saw the deceased alive on 11-20-57 , 19 57 , and that death occurred at 8:45 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3001 Cheverly Ave., Cheverly, Md. DATE SIGNED Nov 26 57							
ACTUAL SIGNATURE B. Van Gelderen M.D.							
PHYSICIAN'S NAME (Type) Dr. Bertha Van Gelderen		3001 Cheverly Ave., Cheverly, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 11/23/57		22c. NAME OF CEMETERY OR CREMATORY Medamity Park		22d. LOCATION (City, town, or county) (State) Chesley Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Dr. Will Sanderson		ADDRESS Lanham Md		24a. REC'D BY REGISTRAR DATE NOV 26 57		24b. REGISTRAR'S SIGNATURE Reel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 26 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12204

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. The funeral director: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. This is designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Hill		c. LENGTH OF STAY IN 1b 1 1/2 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3311 Terrace Drive		d. STREET ADDRESS 3311 Terrace Drive	
3. NAME OF DECEASED (Type or print) James Franklin Burroughs		4. DATE OF DEATH Month Nov. Day 12, Year 19 57	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-19-25
9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Airman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Air Force	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elborn Burroughs		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Currently		16. SOCIAL SECURITY NO.	
17. INFORMANT Winnie Burroughs; same address		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hanging DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanging. Self execution.	
20c. TIME OF INJURY Month, Day, Year 7.00 p.m. 11-11-57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Silver Hill, Pr. Geo. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> November 12, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-15-57	22c. NAME OF CEMETERY OR CREMATORY Arlington Natl.	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co.		24a. REC'D BY REGISTRAR NOV 14 1957	
ADDRESS 517-11th St. S.E.		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

MASSACHUSETTS DEPARTMENT OF HEALTH - BARNHART
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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BUREAU V. E.

NOV 14 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12205

12256

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ammendale Beltsville		c. LENGTH OF STAY IN 1b POL4 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ammendale Normal Institute		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Brother Ephrem Faber Michael Joseph Cantwell		4. DATE OF DEATH Month November Day 28th, Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Christian Brother		10b. KIND OF BUSINESS OR INDUSTRY Religious Order	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Cantwell		14. MOTHER'S MAIDEN NAME Bridget Deevy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Records Ammendale Normal Institute		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Failure 2 hr 422.1 DUE TO (b) Arteriosclerosis C.V. dis 10 yr Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Gen'l arteriosclerosis 70 yr PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Asthma and Emphysema 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 1/5/96 19 to 1/28 19 57, that I last saw the deceased alive on 1/26/57 19, and that death occurred at 1/28 M, from the causes and on the date stated above. ACTUAL SIGNATURE J M Warren M.D. ADDRESS (Street, city or town, state) DATE SIGNED 1/28/57 PHYSICIAN'S NAME (Type) J M WARREN 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 12/2/1957 22c. NAME OF CEMETERY OR CREMATORY Private Cemetery Ammendale Normal Inst. Beltsville, Pr. Geo. Co. 23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md. 24a. REC'D BY REGISTRAR DATE DEC 3 '57 24b. REGISTRAR'S SIGNATURE Md.			

BUREAU V. S.

DEC 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12206
CERTIFICATE OF DEATH

12206

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George General</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>PG</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lewisdale Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u>		d. STREET ADDRESS <u>2261 Mannon Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sue</u> Middle <u>E.</u> Last <u>Carroll</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>8</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>69</u> yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Saleslady</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Woodward & Lothrop</u>	
10a. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		10b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
11. FATHER'S NAME <u>ELMORE</u>		12. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		14. SOCIAL SECURITY NO. <u>578-24-3644</u>	
15. INFORMANT <u>Mrs. Edward Davis (Neighbor)</u>		Address <u>Same as above</u>	
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral infarction</u> <u>581.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bacterial Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>57</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-1</u> , 19 <u>57</u> , to <u>11-7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-7</u> , 19 <u>57</u> , and that death occurred at <u>9:15 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leon L. Gallin</u>		ADDRESS (Street, city or town, state) <u>7206 Colesville Rd. Hyattsville, Md.</u>	
DATE SIGNED <u>11/8/57</u>			
PHYSICIAN'S NAME (Type) <u>LEON L. GALLIN</u>		<u>7206 Colesville Rd. Hyattsville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-11-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u>		ADDRESS <u>3821-14th St NW</u>	
24a. REC'D BY REGISTRAR <u>NOV 12 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		M		35		JAN 5 1928		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT	
JAN 6 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		JAN 8 1968		MEMPHIS		MEMPHIS	
DATE OF REPORT		PLACE OF REPORT		CITY OF REPORT		STATE OF REPORT		COUNTRY OF REPORT		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE	
JAN 10 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		JAN 10 1968		MEMPHIS		MEMPHIS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

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NOV 12 1957
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 223 12-2-57 et

CERTIFICATE OF DEATH

12207

Reg. Dist. No.

12207

1. PLACE OF DEATH o. COUNTY <u>Prince George Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale, Md.</u>				c. LENGTH OF STAY IN 1b <u>3 days + 2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hospital</u>				d. STREET ADDRESS <u>Laurel Race Track</u>			
3. NAME OF DECEASED (Type or print) First <u>Allen</u> Middle <u>Chapman</u> Last <u>Chapman</u>				4. DATE OF DEATH Month <u>11</u> Day <u>20</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>Unknown</u>		8. DATE OF BIRTH <u>7-12-1892</u>		9. AGE (In years last birthday) <u>65</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Odd Jobs</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Race Tracks</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Chapman</u>				14. MOTHER'S MAIDEN NAME <u>Naomi Gordon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Information from patient before death.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cochineal (inability to eat)</u> <u>146X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastasis to cervical nodes</u> DUE TO (c) <u>Carcinoma of Nasopharynx</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2-3 wks</u> <u>1 mo</u> <u>6-12 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11-17</u> , 19 <u>57</u> , to <u>11-20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-19</u> , 19 <u>57</u> , and that death occurred at <u>6:35 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. F. Wilkinson</u>				ADDRESS (Street, city or town, state) <u>4404 Queensberry Road</u>			
PHYSICIAN'S NAME (Type) <u>ROWLAND F. WILKINSON</u>				DATE SIGNED <u>11-20-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11-20-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>K. of Md. Med. School</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers</u>				ADDRESS <u>Riverdale</u>		24a. REC'D BY REGISTRAR DATE <u>2 2 '57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Al. Leach</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12208

CERTIFICATE OF DEATH

12208

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Dodge City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				d. STREET ADDRESS <u>Rt. 2 Box 264</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Chisley</u> Last				4. DATE OF DEATH Month <u>Nov.</u> Day <u>10</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>17 Apr. 1883</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Estelle ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mary L. Chisley</u> Address <u>Dodge City, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure</u> <u>903.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Advanced nephrosclerosis</u> DUE TO <u>hypertension, arteriosclerosis & hyperlipidemia</u> (c) <u>Controlled & treated</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall on street while walking</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>11-1-1957</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>STREET</u>	
20f. (City or town) <u>P. Geo. - Md.</u>				(County) (State)			
21. I certify that I attended the deceased from <u>Nov. 2</u> , 1957, to <u>Nov. 10</u> , 1957, that I last saw the deceased alive on <u>Nov. 10</u> , 1957, and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Peter I. Kenmore</u> M.D. <u>4314 Galatin Street, Hyattsville, Md.</u>				DATE SIGNED <u>Nov 13 1957</u>			
PHYSICIAN'S NAME (Type) <u>PETER I. KENMORE, M.D.</u>				Counter-signed <u>John J. Maloney, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>First Baptist Church</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Arden, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Maloney</u> ADDRESS <u>30 H Street, N.E.</u>				24a. REC'D BY REGISTRAR <u>Nov 13 57</u>		24b. REGISTRAR'S SIGNATURE <u>Maloney</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF CORONER		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF CLERGYMAN	
16. SIGNATURE OF MINISTER		17. SIGNATURE OF CHURCH		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF BURIAL PLACE		20. SIGNATURE OF CEMETERY		21. SIGNATURE OF INTERMENT	
22. SIGNATURE OF CREMATION		23. SIGNATURE OF REINTERMENT		24. SIGNATURE OF REINTERMENT	
25. SIGNATURE OF REINTERMENT		26. SIGNATURE OF REINTERMENT		27. SIGNATURE OF REINTERMENT	
28. SIGNATURE OF REINTERMENT		29. SIGNATURE OF REINTERMENT		30. SIGNATURE OF REINTERMENT	
31. SIGNATURE OF REINTERMENT		32. SIGNATURE OF REINTERMENT		33. SIGNATURE OF REINTERMENT	
34. SIGNATURE OF REINTERMENT		35. SIGNATURE OF REINTERMENT		36. SIGNATURE OF REINTERMENT	
37. SIGNATURE OF REINTERMENT		38. SIGNATURE OF REINTERMENT		39. SIGNATURE OF REINTERMENT	
40. SIGNATURE OF REINTERMENT		41. SIGNATURE OF REINTERMENT		42. SIGNATURE OF REINTERMENT	
43. SIGNATURE OF REINTERMENT		44. SIGNATURE OF REINTERMENT		45. SIGNATURE OF REINTERMENT	
46. SIGNATURE OF REINTERMENT		47. SIGNATURE OF REINTERMENT		48. SIGNATURE OF REINTERMENT	
49. SIGNATURE OF REINTERMENT		50. SIGNATURE OF REINTERMENT		51. SIGNATURE OF REINTERMENT	
52. SIGNATURE OF REINTERMENT		53. SIGNATURE OF REINTERMENT		54. SIGNATURE OF REINTERMENT	
55. SIGNATURE OF REINTERMENT		56. SIGNATURE OF REINTERMENT		57. SIGNATURE OF REINTERMENT	
58. SIGNATURE OF REINTERMENT		59. SIGNATURE OF REINTERMENT		60. SIGNATURE OF REINTERMENT	
61. SIGNATURE OF REINTERMENT		62. SIGNATURE OF REINTERMENT		63. SIGNATURE OF REINTERMENT	
64. SIGNATURE OF REINTERMENT		65. SIGNATURE OF REINTERMENT		66. SIGNATURE OF REINTERMENT	
67. SIGNATURE OF REINTERMENT		68. SIGNATURE OF REINTERMENT		69. SIGNATURE OF REINTERMENT	
70. SIGNATURE OF REINTERMENT		71. SIGNATURE OF REINTERMENT		72. SIGNATURE OF REINTERMENT	
73. SIGNATURE OF REINTERMENT		74. SIGNATURE OF REINTERMENT		75. SIGNATURE OF REINTERMENT	
76. SIGNATURE OF REINTERMENT		77. SIGNATURE OF REINTERMENT		78. SIGNATURE OF REINTERMENT	
79. SIGNATURE OF REINTERMENT		80. SIGNATURE OF REINTERMENT		81. SIGNATURE OF REINTERMENT	
82. SIGNATURE OF REINTERMENT		83. SIGNATURE OF REINTERMENT		84. SIGNATURE OF REINTERMENT	
85. SIGNATURE OF REINTERMENT		86. SIGNATURE OF REINTERMENT		87. SIGNATURE OF REINTERMENT	
88. SIGNATURE OF REINTERMENT		89. SIGNATURE OF REINTERMENT		90. SIGNATURE OF REINTERMENT	
91. SIGNATURE OF REINTERMENT		92. SIGNATURE OF REINTERMENT		93. SIGNATURE OF REINTERMENT	
94. SIGNATURE OF REINTERMENT		95. SIGNATURE OF REINTERMENT		96. SIGNATURE OF REINTERMENT	
97. SIGNATURE OF REINTERMENT		98. SIGNATURE OF REINTERMENT		99. SIGNATURE OF REINTERMENT	
100. SIGNATURE OF REINTERMENT		101. SIGNATURE OF REINTERMENT		102. SIGNATURE OF REINTERMENT	

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NOV 13 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. The funeral director: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. This is designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12257

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12209

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Univ. Park		c. LENGTH OF STAY IN lb 9 Yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Univ. Park		d. STREET ADDRESS 6512 40th. Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RUTH TROUTMAN COOK		4. DATE OF DEATH Nov. 6 19 57		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 26 May 1905		9. AGE (In years last birthday) 52 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Mo.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Charles Troutman		14. MOTHER'S MAIDEN NAME Emily Hoyt		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Harold T. Cook (Husband)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO (b) Cardiovascular renal disease DUE TO (c) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) JOHN T. MALONEY, M.D.		DATE SIGNED 11/6/57		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/8/57		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) Arlington Va.		23. FUNERAL DIRECTOR'S SIGNATURE F. GASCH'S SONS		ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR NOV 12 57		24b. REGISTRAR'S SIGNATURE W. H. ...	

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NOV 12 1957

BUREAU V. H.

RECEIVED

NOV 12 1957

BUREAU V. H.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
FURNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

12209

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12210

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4111 51st Street		d. STREET ADDRESS 4111 51st Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Caroline Middle Cowan Last Cowan		4. DATE OF DEATH Month November Day 15 Year 19 57	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1868
9. AGE (In years last birthday) 89 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY London, England	
11. BIRTHPLACE (State or foreign country) London, England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ruth Rice, same address as # 2.		14. MOTHER'S MAIDEN NAME Rose Nicholsburg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT Ruth Rice, same address as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic heart disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO (c) Senility			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED November 15, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/18/57	
22c. NAME OF CEMETERY OR CREMATORIAL George Washington		22d. LOCATION (City, town, or county) (State) Hyattsville, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		ADDRESS	
24a. REC'D BY REGISTRAR NOV 19 57		24b. REGISTRAR'S SIGNATURE Alf. Leach	

—MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

NOV 19 1957

RECEIVED

22a. BURIAL, CREMATION, BURIAL (Specify)	22b. DATE THEREOF Nov. 9/57	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	22d. LOCATION (City, town, or county) Colmar Manor,	(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Loesch Funeral Home</i>		ADDRESS <i>4734 Belts Ave. Hyalts., Md</i>	24a. REC'D BY REGISTRAR DATE NOV 12 1957	24b. REGISTRAR'S SIGNATURE <i>James Hoover</i>

VS A15 (4)
15M 9/55

RECEIVED

12182

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 8 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4603 Edmonston Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Martin Harold Neal		4. DATE OF DEATH November 16, 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1930
9. AGE (In years last birthday) 27 yrs.		10. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew J. Grigger		14. MOTHER'S MAIDEN NAME Bessie Dillman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Evelyn Grigger;		Address same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide poisoning and 2nd, 3rd & 916.0 xxxx degree burns of 100 % of body. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Conflagration in home (c) Conflagration in home PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Conflagration in home INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fire in home. Deceased overcome by fumes.	
20c. TIME OF INJURY Month, Day, Year 2.00 a.m. 11-16-1957		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Hyattsville, Pr. Geo. Md. (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Nov. 16, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/19/57	
22c. NAME OF CEMETERY OR REMOVAL Arlington National		22d. LOCATION (City, town, or county) Arlington Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR Nov 19 1957		24b. REGISTRAR'S SIGNATURE James Henry	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. The funeral director: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. This is designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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NOV 19 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12211

CERTIFICATE OF DEATH

12213

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>PG</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly, Md</u>				c. LENGTH OF STAY IN 1b <u>1 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Hillside, Md.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u>				d. STREET ADDRESS <u>1510 59th Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James A.</u> Middle <u>Cusick</u> Last				4. DATE OF DEATH Month <u>Nov.</u> Day <u>27</u> Year <u>19 57</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-10-80</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elevator operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Statler Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Farrell</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT Wife. <u>Beulah Cusick</u> Address <u>Same as above</u>				
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> <u>154X</u> DUE TO <u>Metastatic carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the Rectum</u> DUE TO (c) <u>Carcinoma, Rectum</u>							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Nov 26, 19 57</u> to <u>Nov 27, 19 57</u> that I last saw the deceased alive on <u>Nov 26, 19 57</u> , and that death occurred at <u>2:00A</u> M, from the causes and on the date stated above.								
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>5802 Baltimore Ave Hyattsville Md.</u>				DATE SIGNED <u>DEC 2 '57</u>
PHYSICIAN'S NAME (Type) <u>Dr. L Deitz</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-30-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS</u>				ADDRESS <u>Q-517-11 D 5756 WASH. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 2 '57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

DEC 2 1957

BUREAU V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, register prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12214

12258

CERTIFICATE OF DEATH

Reg. Dist. No.

734

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Run Hills</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Run Hills</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2407 Southern Ave.</u>				d. STREET ADDRESS <u>2407 Southern Ave</u>			
3. NAME OF DECEASED (Type or print) <u>EMMA ELIZABETH DENHAM</u>				4. DATE OF DEATH Month <u>NOV</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 29 1869</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pottstown, Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ERVIN ERB</u>				14. MOTHER'S MAIDEN NAME <u>Clara Childs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs Dorothy E. Riddle</u> Address <u>2407 Southern Ave Oxon Run Hills MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>442X</u> DUE TO <u>Chronic Cardio-Vascular Reflux</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Sclerosis</u> (b) <u>Sclerosis</u> (c)							INTERVAL BETWEEN ONSET AND DEATH <u>50 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Osteoporosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 14</u> , 19 <u>57</u> , to <u>13 Nov</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>13 Nov</u> , 19 <u>57</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert C. Hale</u> M.D.				ADDRESS (Street, city or town, state) <u>3574 Jane NW Wash D.C.</u> DATE SIGNED <u>18 Nov 57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-21-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers & Co. Washington, D.C.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>NOV 26 1957</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

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NOV 26 1957

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, pages 1 and 2 should be filled with
page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers, pages 1 and 2 should be filled with
registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12212

Items 9, 11 Film 6222 11-21-57 et

CERTIFICATE OF DEATH

12215

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 14704 College Park 14704 Norwich Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Baby Girl A Dixon				4. DATE OF DEATH Month Nov. Day 1 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 Nov. 1957	
9. AGE (In years last birthday) yrs. 2				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) P. G. Gen. Hosp. Cheverly, Md.	
13. FATHER'S NAME Richard Dixon				14. MOTHER'S MAIDEN NAME Sandra Campbell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 769.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Toxemia Preg DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 24 1 week							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov 1st , 19 57 , to Nov 1 , 19 57 , that I last saw the deceased alive on Nov 1st , 19 57 , and that death occurred at 3:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hyattsville, Md. DATE SIGNED ACTUAL SIGNATURE G. W. Kelley, M. D. PHYSICIAN'S NAME (Type) Hyattsville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE OF BURIAL 11/7/57		22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr., Administrator.				24a. REC'D BY REGISTRAR DATE NOV 13 '57		24b. REGISTRAR'S SIGNATURE W. H. Beach	

2177201XVO

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		M		35		APR 4 1968		MEMPHIS, TENNESSEE	
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED	
OCCUPATION		BUSINESSMAN		LABORER		FARMER		OTHER	
EDUCATION		HIGH SCHOOL		COLLEGE		UNIVERSITY		OTHER	
CAUSE OF DEATH		HEART DISEASE		CANCER		INFECTION		OTHER	
MANNER OF DEATH		NATURAL		ACCIDENT		SUICIDE		HOMICIDE	
CERTIFICATE OF DEATH		FEDERAL BUREAU OF INVESTIGATION		DEPARTMENT OF JUSTICE		UNITED STATES OF AMERICA		WASHINGTON, D.C.	

BUREAU V. S.

NOV 13 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filled with the information requested. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 9, 11 Film 0222 11-21-57 et
12213
CERTIFICATE OF DEATH

12216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>	
c. LENGTH OF STAY IN 1b <u>2 hours</u>		d. STREET ADDRESS <u>4704 Norwich Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>B Dixon</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>1</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1 Nov 57</u>
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>P.G. Gen. Hosp., Cheverly, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Richard Dixon</u>		14. MOTHER'S MAIDEN NAME <u>Sandra Campbell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Sandra Campbell</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>769.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Toxemia Pregnancy</u> DUE TO (c) <u>1 week</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 1st, 1957</u> , to <u>Nov 1st, 1957</u> , that I last saw the deceased alive on <u>Nov 1st, 1957</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. W. Kelley</u>		DATE SIGNED <u>Hyattsville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>G. W. Kelley, Md D.</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>11/7/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prince Georges General Hospital, Cheverly, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry W. Penn, Jr.</u>		24a. REC'D BY REGISTRAR <u>Nov 13 '57</u>	
24b. REGISTRAR'S SIGNATURE <u>R. L. Search</u>		24c. ADDRESS	

2277292XVO

Administrator.

MARYLAND STATE DEPARTMENT OF HEALTH - CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
RACE [Faint text]		BIRTH DATE [Faint text]		BIRTH PLACE [Faint text]	
MARRIAGE [Faint text]		OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
PLACE OF DEATH [Faint text]		DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF CORONER [Faint text]		SIGNATURE OF DECEASED [Faint text]	
SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF WITNESS [Faint text]	

BUREAU V. 2

NOV 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12217

12183

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Home</u>				d. STREET ADDRESS <u>5805-Queens Chapel Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>SARAH</u> First <u>A. DOHERTY</u> Middle <u>DOHERTY</u> Last				4. DATE OF DEATH <u>11</u> - <u>8</u> - <u>1957</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/2/1862</u> <u>95</u> yrs.	
9. AGE (In years last birthday) <u>95</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>IN OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Henry Aindow</u>		14. MOTHER'S MAIDEN NAME <u>Kelly</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Agathy Jamison</u>		Address <u>3717-Sheppard St. Brentwood, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR HEMORRHAGE</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>15 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>MAY 2</u> , 19 <u>56</u> , to <u>NOV 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>NOV 6</u> , 19 <u>57</u> , and that death occurred at <u>6:00</u> A.M., from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Thomas F. Collins</u> M.D. <u>322-H St NE</u>				PHYSICIAN'S NAME (Type) <u>Thomas F. Collins</u> <u>Washington 2, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-11-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u> ADDRESS <u>3200-R.I. AVE Mt. Rainier, Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 12 1957</u>		24b. REGISTRAR'S SIGNATURE <u>James L. ...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG 27-10

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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BUREAU V. 1

NOV 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12218

12184

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville Md.	
c. LENGTH OF STAY IN 1b 2 years		d. STREET ADDRESS 5501 42nd Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5501 42nd Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN JOSEPH DOLAN		4. DATE OF DEATH Month Day Year NOV 12 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-26-1876
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME MICHAEL Dolan		14. MOTHER'S MAIDEN NAME ANN GOUGHN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. SCHULTZ, daughter		Address - same address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154x Carcinoma of Rectum DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2-3 MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 1956, to Nov. 12, 1957, that I last saw the deceased alive on Nov. 10, 1957, and that death occurred at M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Arnold A. Lear		ADDRESS (Street, city or town, state) 905 Sheridan St. DATE SIGNED 11-12-57	
PHYSICIAN'S NAME (Type) ARNOLD A. LEAR MD. Hyattsville Md.			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial	22b. DATE THEREOF Nov 14, 1957	22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Washington D. C.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.		24a. REC'D BY REGISTRAR DATE NOV 15 1957 24b. REGISTRAR'S SIGNATURE James E. Levere	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF WITNESS</p>		<p>15. SIGNATURE OF WITNESS</p>		<p>16. SIGNATURE OF WITNESS</p>	
<p>17. SIGNATURE OF WITNESS</p>		<p>18. SIGNATURE OF WITNESS</p>		<p>19. SIGNATURE OF WITNESS</p>		<p>20. SIGNATURE OF WITNESS</p>	
<p>21. SIGNATURE OF WITNESS</p>		<p>22. SIGNATURE OF WITNESS</p>		<p>23. SIGNATURE OF WITNESS</p>		<p>24. SIGNATURE OF WITNESS</p>	
<p>25. SIGNATURE OF WITNESS</p>		<p>26. SIGNATURE OF WITNESS</p>		<p>27. SIGNATURE OF WITNESS</p>		<p>28. SIGNATURE OF WITNESS</p>	
<p>29. SIGNATURE OF WITNESS</p>		<p>30. SIGNATURE OF WITNESS</p>		<p>31. SIGNATURE OF WITNESS</p>		<p>32. SIGNATURE OF WITNESS</p>	
<p>33. SIGNATURE OF WITNESS</p>		<p>34. SIGNATURE OF WITNESS</p>		<p>35. SIGNATURE OF WITNESS</p>		<p>36. SIGNATURE OF WITNESS</p>	
<p>37. SIGNATURE OF WITNESS</p>		<p>38. SIGNATURE OF WITNESS</p>		<p>39. SIGNATURE OF WITNESS</p>		<p>40. SIGNATURE OF WITNESS</p>	
<p>41. SIGNATURE OF WITNESS</p>		<p>42. SIGNATURE OF WITNESS</p>		<p>43. SIGNATURE OF WITNESS</p>		<p>44. SIGNATURE OF WITNESS</p>	
<p>45. SIGNATURE OF WITNESS</p>		<p>46. SIGNATURE OF WITNESS</p>		<p>47. SIGNATURE OF WITNESS</p>		<p>48. SIGNATURE OF WITNESS</p>	
<p>49. SIGNATURE OF WITNESS</p>		<p>50. SIGNATURE OF WITNESS</p>		<p>51. SIGNATURE OF WITNESS</p>		<p>52. SIGNATURE OF WITNESS</p>	
<p>53. SIGNATURE OF WITNESS</p>		<p>54. SIGNATURE OF WITNESS</p>		<p>55. SIGNATURE OF WITNESS</p>		<p>56. SIGNATURE OF WITNESS</p>	
<p>57. SIGNATURE OF WITNESS</p>		<p>58. SIGNATURE OF WITNESS</p>		<p>59. SIGNATURE OF WITNESS</p>		<p>60. SIGNATURE OF WITNESS</p>	
<p>61. SIGNATURE OF WITNESS</p>		<p>62. SIGNATURE OF WITNESS</p>		<p>63. SIGNATURE OF WITNESS</p>		<p>64. SIGNATURE OF WITNESS</p>	
<p>65. SIGNATURE OF WITNESS</p>		<p>66. SIGNATURE OF WITNESS</p>		<p>67. SIGNATURE OF WITNESS</p>		<p>68. SIGNATURE OF WITNESS</p>	
<p>69. SIGNATURE OF WITNESS</p>		<p>70. SIGNATURE OF WITNESS</p>		<p>71. SIGNATURE OF WITNESS</p>		<p>72. SIGNATURE OF WITNESS</p>	
<p>73. SIGNATURE OF WITNESS</p>		<p>74. SIGNATURE OF WITNESS</p>		<p>75. SIGNATURE OF WITNESS</p>		<p>76. SIGNATURE OF WITNESS</p>	
<p>77. SIGNATURE OF WITNESS</p>		<p>78. SIGNATURE OF WITNESS</p>		<p>79. SIGNATURE OF WITNESS</p>		<p>80. SIGNATURE OF WITNESS</p>	
<p>81. SIGNATURE OF WITNESS</p>		<p>82. SIGNATURE OF WITNESS</p>		<p>83. SIGNATURE OF WITNESS</p>		<p>84. SIGNATURE OF WITNESS</p>	
<p>85. SIGNATURE OF WITNESS</p>		<p>86. SIGNATURE OF WITNESS</p>		<p>87. SIGNATURE OF WITNESS</p>		<p>88. SIGNATURE OF WITNESS</p>	
<p>89. SIGNATURE OF WITNESS</p>		<p>90. SIGNATURE OF WITNESS</p>		<p>91. SIGNATURE OF WITNESS</p>		<p>92. SIGNATURE OF WITNESS</p>	
<p>93. SIGNATURE OF WITNESS</p>		<p>94. SIGNATURE OF WITNESS</p>		<p>95. SIGNATURE OF WITNESS</p>		<p>96. SIGNATURE OF WITNESS</p>	
<p>97. SIGNATURE OF WITNESS</p>		<p>98. SIGNATURE OF WITNESS</p>		<p>99. SIGNATURE OF WITNESS</p>		<p>100. SIGNATURE OF WITNESS</p>	

BUREAU V. S.

NOV 15 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12180

CERTIFICATE OF DEATH

Reg. Dist. No.

12219

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4717 Nantucket Road				d. STREET ADDRESS 4717 Nantucket Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First FRANK Middle (NMN) Last DOMAGALSKI				4. DATE OF DEATH Month Nov. Day 14th Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 22/1883	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator				10b. KIND OF BUSINESS OR INDUSTRY Lumber Business		11. BIRTHPLACE (State or foreign country) Silver Lake, Minn.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Peter Domagalski				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 477-03-1295		17. INFORMANT Dorothy K. Masek, 4717 Nantucket Road, College Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 3 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Previous CVA - 4 mos previously						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. n. Month 19 Day 13 Year 1957 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1 , 19 53 , to Nov 14 , 19 57 , that I last saw the deceased alive on Nov 13 , 19 57 , and that death occurred at 7:20 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John Kehoe M.D.				ADDRESS (Street, city or town, state) 3404 Cheverly Ave., Cheverly, Md.			
DATE SIGNED 11/14/1957							
PHYSICIAN'S NAME (Type) John Kehoe							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/18/1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				ADDRESS 		24a. REC'D BY REGISTRAR DATE NOV 20 '57	
				24b. REGISTRAR'S SIGNATURE W. W. Chambers			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, who is to be filled in by the funeral director, Pages 1 and 2 should be filled with the name of the deceased, and in any event within 72 hours after death. Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12220

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X0 Glenarden Md	
c. LENGTH OF STAY IN 1b 25 hrs.		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles James Duvall		4. DATE OF DEATH Nov. 6 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 17-1892
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labour		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac Duvall		14. MOTHER'S MAIDEN NAME Harriett West	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Oldest Son 61		Address Randolph Pl	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Hydrothorax, Congestive Heart Failure. Perforation of Aortic Valve. 420.0 DUE TO 45 hrs. (b) Anteroseptal Heart Disease DUE TO 45 hrs. (c) YEARS.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral Abscesses of Psoas Muscles, probably Tuberculous.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-6, 1957, to 11-6, 1957, that I last saw the deceased alive on 11-6, 1957, and that death occurred at 7:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Trinidad T. Salazar		DATE SIGNED Nov. 8, 1957	
PHYSICIAN'S NAME (Type) TRINIDAD T. SALAZAR			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 11-12-57	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Dunning Rd. N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Jerry S. Washington		ADDRESS 467 N st. N.C.	
24a. REC'D BY REGISTRAR DATE NOV 13 '57		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. AGE 35		4. RACE White	
5. DATE OF DEATH April 4, 1968		6. PLACE OF DEATH Memphis, Tennessee	
7. TIME OF DEATH 2:01 PM		8. CAUSE OF DEATH Shot - Gun	
9. MANNER OF DEATH Suicide		10. SIGNATURE OF DECEASED (None)	
11. SIGNATURE OF WITNESSES (None)		12. SIGNATURE OF DECEASED'S PHYSICIAN (None)	
13. SIGNATURE OF DECEASED'S NEAREST RELATIVE (None)		14. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL (None)	
15. SIGNATURE OF DECEASED'S CHURCH CLERK (None)		16. SIGNATURE OF DECEASED'S EMPLOYER (None)	
17. SIGNATURE OF DECEASED'S SCHOOL TEACHER (None)		18. SIGNATURE OF DECEASED'S SOCIAL SECURITY OFFICIAL (None)	
19. SIGNATURE OF DECEASED'S POSTAL OFFICIAL (None)		20. SIGNATURE OF DECEASED'S INSURANCE AGENT (None)	
21. SIGNATURE OF DECEASED'S BANK CLERK (None)		22. SIGNATURE OF DECEASED'S TAXPAYER (None)	
23. SIGNATURE OF DECEASED'S EMPLOYER (None)		24. SIGNATURE OF DECEASED'S EMPLOYER (None)	
25. SIGNATURE OF DECEASED'S EMPLOYER (None)		26. SIGNATURE OF DECEASED'S EMPLOYER (None)	
27. SIGNATURE OF DECEASED'S EMPLOYER (None)		28. SIGNATURE OF DECEASED'S EMPLOYER (None)	
29. SIGNATURE OF DECEASED'S EMPLOYER (None)		30. SIGNATURE OF DECEASED'S EMPLOYER (None)	
31. SIGNATURE OF DECEASED'S EMPLOYER (None)		32. SIGNATURE OF DECEASED'S EMPLOYER (None)	
33. SIGNATURE OF DECEASED'S EMPLOYER (None)		34. SIGNATURE OF DECEASED'S EMPLOYER (None)	
35. SIGNATURE OF DECEASED'S EMPLOYER (None)		36. SIGNATURE OF DECEASED'S EMPLOYER (None)	
37. SIGNATURE OF DECEASED'S EMPLOYER (None)		38. SIGNATURE OF DECEASED'S EMPLOYER (None)	
39. SIGNATURE OF DECEASED'S EMPLOYER (None)		40. SIGNATURE OF DECEASED'S EMPLOYER (None)	
41. SIGNATURE OF DECEASED'S EMPLOYER (None)		42. SIGNATURE OF DECEASED'S EMPLOYER (None)	
43. SIGNATURE OF DECEASED'S EMPLOYER (None)		44. SIGNATURE OF DECEASED'S EMPLOYER (None)	
45. SIGNATURE OF DECEASED'S EMPLOYER (None)		46. SIGNATURE OF DECEASED'S EMPLOYER (None)	
47. SIGNATURE OF DECEASED'S EMPLOYER (None)		48. SIGNATURE OF DECEASED'S EMPLOYER (None)	
49. SIGNATURE OF DECEASED'S EMPLOYER (None)		50. SIGNATURE OF DECEASED'S EMPLOYER (None)	
51. SIGNATURE OF DECEASED'S EMPLOYER (None)		52. SIGNATURE OF DECEASED'S EMPLOYER (None)	
53. SIGNATURE OF DECEASED'S EMPLOYER (None)		54. SIGNATURE OF DECEASED'S EMPLOYER (None)	
55. SIGNATURE OF DECEASED'S EMPLOYER (None)		56. SIGNATURE OF DECEASED'S EMPLOYER (None)	
57. SIGNATURE OF DECEASED'S EMPLOYER (None)		58. SIGNATURE OF DECEASED'S EMPLOYER (None)	
59. SIGNATURE OF DECEASED'S EMPLOYER (None)		60. SIGNATURE OF DECEASED'S EMPLOYER (None)	
61. SIGNATURE OF DECEASED'S EMPLOYER (None)		62. SIGNATURE OF DECEASED'S EMPLOYER (None)	
63. SIGNATURE OF DECEASED'S EMPLOYER (None)		64. SIGNATURE OF DECEASED'S EMPLOYER (None)	
65. SIGNATURE OF DECEASED'S EMPLOYER (None)		66. SIGNATURE OF DECEASED'S EMPLOYER (None)	
67. SIGNATURE OF DECEASED'S EMPLOYER (None)		68. SIGNATURE OF DECEASED'S EMPLOYER (None)	
69. SIGNATURE OF DECEASED'S EMPLOYER (None)		70. SIGNATURE OF DECEASED'S EMPLOYER (None)	
71. SIGNATURE OF DECEASED'S EMPLOYER (None)		72. SIGNATURE OF DECEASED'S EMPLOYER (None)	
73. SIGNATURE OF DECEASED'S EMPLOYER (None)		74. SIGNATURE OF DECEASED'S EMPLOYER (None)	
75. SIGNATURE OF DECEASED'S EMPLOYER (None)		76. SIGNATURE OF DECEASED'S EMPLOYER (None)	
77. SIGNATURE OF DECEASED'S EMPLOYER (None)		78. SIGNATURE OF DECEASED'S EMPLOYER (None)	
79. SIGNATURE OF DECEASED'S EMPLOYER (None)		80. SIGNATURE OF DECEASED'S EMPLOYER (None)	
81. SIGNATURE OF DECEASED'S EMPLOYER (None)		82. SIGNATURE OF DECEASED'S EMPLOYER (None)	
83. SIGNATURE OF DECEASED'S EMPLOYER (None)		84. SIGNATURE OF DECEASED'S EMPLOYER (None)	
85. SIGNATURE OF DECEASED'S EMPLOYER (None)		86. SIGNATURE OF DECEASED'S EMPLOYER (None)	
87. SIGNATURE OF DECEASED'S EMPLOYER (None)		88. SIGNATURE OF DECEASED'S EMPLOYER (None)	
89. SIGNATURE OF DECEASED'S EMPLOYER (None)		90. SIGNATURE OF DECEASED'S EMPLOYER (None)	
91. SIGNATURE OF DECEASED'S EMPLOYER (None)		92. SIGNATURE OF DECEASED'S EMPLOYER (None)	
93. SIGNATURE OF DECEASED'S EMPLOYER (None)		94. SIGNATURE OF DECEASED'S EMPLOYER (None)	
95. SIGNATURE OF DECEASED'S EMPLOYER (None)		96. SIGNATURE OF DECEASED'S EMPLOYER (None)	
97. SIGNATURE OF DECEASED'S EMPLOYER (None)		98. SIGNATURE OF DECEASED'S EMPLOYER (None)	
99. SIGNATURE OF DECEASED'S EMPLOYER (None)		100. SIGNATURE OF DECEASED'S EMPLOYER (None)	

BUREAU V. 4

NOV 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12259

CERTIFICATE OF DEATH

Reg. Dist. No.

12221

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Upper Marlboro			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rectory Lane				d. STREET ADDRESS 1 Rectory Lane			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Nellie Middle S. Last Early				4. DATE OF DEATH Month November Day 17 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4, 1879		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 7 Days 19 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Henry Squires				14. MOTHER'S MAIDEN NAME Mary Rose Garner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Roland Richardson-Upper Marlboro, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Cardiac Decompensation DUE TO (b) Hypertensive C.V.R. Disease DUE TO (c) Nephrectomy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 16 hrs Unknown 1923	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Baden		(County) (State)	
21. I certify that I attended the deceased from Mar , 19 50 , to 12 Nov , 19 52 , that I last saw the deceased alive on 12 Nov , 19 52 , and that death occurred at 5:00 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert B. Sasser M.D.				ADDRESS (Street, city or town, state) Upper Marlboro, Md. DATE SIGNED 18 Nov 57			
PHYSICIAN'S NAME (Type) Robert B. Sasser, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/20/57		22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		22d. LOCATION (City, town, or county) (State) Baden, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home-Marlboro, Md.				24a. REC'D BY REGISTRAR NOV 25 '57		24b. REGISTRAR'S SIGNATURE W. L. Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		65		M		W		1890		BALTIMORE, MD.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION	
1957		BALTIMORE, MD.		HEART DISEASE		NATURAL		FARMER		HIGH SCHOOL	
DATE OF BURIAL		PLACE OF BURIAL		NAME OF FUNERAL HOME		NAME OF MINISTER		NAME OF CHURCH		NAME OF CEMETERY	
1957		BALTIMORE, MD.		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF INTERMENT		PLACE OF INTERMENT		NAME OF INTERMENT HOME		NAME OF MINISTER		NAME OF CHURCH		NAME OF CEMETERY	
1957		BALTIMORE, MD.		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF CREMATION		PLACE OF CREMATION		NAME OF CREMATION HOME		NAME OF MINISTER		NAME OF CHURCH		NAME OF CEMETERY	
1957		BALTIMORE, MD.		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF REINTERMENT		PLACE OF REINTERMENT		NAME OF REINTERMENT HOME		NAME OF MINISTER		NAME OF CHURCH		NAME OF CEMETERY	
1957		BALTIMORE, MD.		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF REINTERMENT		PLACE OF REINTERMENT		NAME OF REINTERMENT HOME		NAME OF MINISTER		NAME OF CHURCH		NAME OF CEMETERY	
1957		BALTIMORE, MD.		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

BUREAU V. 3

NOV 25 1957

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, or
the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12260

CERTIFICATE OF DEATH

12222

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 8 months & 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital			d. STREET ADDRESS 1203 Trenton Pl., S. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle E. Last Fellows			4. DATE OF DEATH Month 11 Day 7 Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9/2/1897	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY 628 E. St., N. W.		11. BIRTHPLACE (State or foreign country) Canada	
13. FATHER'S NAME Samuel Fellows			14. MOTHER'S MAIDEN NAME Edna Morrett		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-01-6893		17. INFORMANT Decedent	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162X Bronchogenic carcinoma, with metastasis to skull DUE TO and ribs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 8 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X Pulmonary tuberculosis, 4 yrs.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/6/19 57, to 11/7/19 57, that I last saw the deceased alive on 11/7/19 57, and that death occurred at 3:45 a.m. from the causes and on the date stated above.					
ACTUAL SIGNATURE Moe Weiss		M.D. Glenn Dale Hospital		DATE SIGNED 11/7/57	
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/11/57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Williams		ADDRESS 300 - 4th St. N.E. Wash. D.C.		24. REG'D BY REGISTRAR DATE NOV 13 '57	
				24b. REGISTRAR'S SIGNATURE R. Beach	

BUREAU A. S.

NOV 13 1957

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12185 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

122232 45

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 17 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3916 Nicholson Street			d. STREET ADDRESS 3916 Nicholson Street		
3. NAME OF DECEASED (Type or print) Hubert Mark Foley			4. DATE OF DEATH Month November Day 21 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1874		9. AGE (In years last birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Painter		11. BIRTHPLACE (State or foreign country) Iowa	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Mark J. Foley			14. MOTHER'S MAIDEN NAME Mary Madden		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Army		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs Theresa Collins; 5404 35th Ave., Hyattsville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) Cardiovascular renal disease (a), stating the underlying cause lost.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		November 21, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 23, 1957		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
22d. LOCATION (City, town, or county) (State) Suitland, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR NOV 25 1957	
				24b. REGISTRAR'S SIGNATURE James L. Lacey	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12215

CERTIFICATE OF DEATH

Reg. Dist. No.

12224

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb 7 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville,			
				d. STREET ADDRESS 4103 Queensberry Rd.			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marie Middle C Last Fox				4. DATE OF DEATH Month November Day 22 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-30-85	
9. AGE (In years lost birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min.		IF UNDER 24 HRS. Months 71 Days 71 Hours 71 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME William H. Niemyer				14. MOTHER'S MAIDEN NAME Mary Momberger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. --		17. INFORMANT Hospital Records Address Cheverly, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Masernic left intra cerebral hemorrhage. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1 deep tension Arterio Sclerotic Hypertension DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 22, 19 57 to Nov. 22, 19 57 , that I last saw the deceased alive on Nov. 22, 19 57 , and that death occurred at 9 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE David Clayman M.D.				ADDRESS (Street, city or town, state) 6311 Baltimore ave Hyattsville, Md			
DATE SIGNED 11/22/57							
PHYSICIAN'S NAME (Type) Dr. David Clayman							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 26, 1957		22c. NAME OF CEMETERY OR CREMATORY Carver Memorial Park		22d. LOCATION (City, town, or county) (State) Muirkirk Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.			
24a. REC'D BY REGISTRAR NOV 25 57				24b. REGISTRAR'S SIGNATURE Qu...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2 should be filled with the name of the funeral home, the name of the funeral director, and the name of the funeral home, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

NOV 25 1957

RECEIVED

12261 CERTIFICATE OF DEATH

12226

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>5116 VST SE</u> <u>BRADBURY HTS</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>5116 VST SE</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRADBURY HTS</u>		c. LENGTH OF STAY IN 1b <u>7 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Maryland Prince G eorges Co.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HORACE</u> Middle <u>R</u> Last <u>FULLER</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 5, 1886</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE F. FULLER</u>		14. MOTHER'S MAIDEN NAME <u>MARY A ROWLAND</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS ELLEN FULLER</u>		Address <u>5116 VST SE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis of Middle Cerebral Artery, Right</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 10, 1948</u> , to <u>Nov 23</u> , 1957, that I last saw the deceased alive on <u>Nov 22</u> , 1957, and that death occurred at <u>8 A. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas S Sappington</u> M.D.		ADDRESS (Street, city or town, state) <u>1025 Connecticut Ave N.W.</u> DATE SIGNED <u>11/23/57</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS S. SAPPINGTON</u>		<u>Washington D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Entombment</u>	<u>Nov 26, 1957</u>	<u>Fort Lincoln Masoleum</u>	<u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 25 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED CAROL ANN BULLOCK</p>		<p>2. SEX F</p>	
<p>3. AGE 35</p>		<p>4. DATE OF BIRTH 11/11/22</p>	
<p>5. PLACE OF BIRTH BALTIMORE, MD</p>		<p>6. OCCUPATION HOUSEWIFE</p>	
<p>7. MARITAL STATUS MARRIED</p>		<p>8. DATE OF MARRIAGE 10/15/50</p>	
<p>9. NAME OF SPOUSE ROBERT L. BULLOCK</p>		<p>10. DATE OF DEATH 11/15/57</p>	
<p>11. PLACE OF DEATH HOME</p>		<p>12. CAUSE OF DEATH HEART DISEASE</p>	
<p>13. MEDICAL HISTORY HYPERTENSION</p>		<p>14. SIGNATURE OF PHYSICIAN [Signature]</p>	
<p>15. SIGNATURE OF REGISTRAR [Signature]</p>		<p>16. OFFICIAL USE [Stamp]</p>	

BUREAU V. S.

NOV 25 1957

RECEIVED

may be retained by the hospital, or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12262

CERTIFICATE OF DEATH

12227

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>P.G. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CORAL HILLS</u>				c. LENGTH OF STAY IN 1b <u>1 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1500-52 Ave SE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>FRANK</u> First <u>J</u> Middle <u>Gentile</u> Last				4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-28-1875</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>18</u> Hours <u>19</u> Min. <u>57</u>		IF UNDER 24 HRS. Months <u>11</u> Days <u>18</u> Hours <u>19</u> Min. <u>57</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Merchant</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>							
13. FATHER'S NAME <u>John Gentile</u>				14. MOTHER'S MAIDEN NAME <u>MAR MITICA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		(If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>John Gentile</u> Address <u>1500 52 Ave SE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Failure - Auricular Fibrillation</u> INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>10-15 years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10/24</u> , 19 <u>57</u> , to <u>11/18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/18</u> , 19 <u>57</u> , and that death occurred at <u>7:30</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas F. Green</u>				ADDRESS (Street, city or town, state) <u>4400 Bowen Road SE, DC</u>			
DATE SIGNED <u>11/18/57</u>							
PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's</u>		22d. LOCATION (City, town, or county) (State) <u>Westport, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E.S. Boal</u>				ADDRESS <u>Westport</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 21 57</u>	
24b. REGISTRAR'S SIGNATURE <u></u>							

CERTIFICATE OF DEATH

Page 1 of 1

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. DATE OF BIRTH		11. TIME OF BIRTH		12. PLACE OF BIRTH	
13. NAME OF PHYSICIAN		14. NAME OF NURSE		15. NAME OF MINISTER	
16. NAME OF FUNERAL HOME		17. NAME OF BURIAL PLACE		18. NAME OF CEMETERY	
19. NAME OF INTERVIEWER		20. NAME OF WITNESS		21. NAME OF SIGNER	
22. NAME OF SIGNER		23. NAME OF SIGNER		24. NAME OF SIGNER	
25. NAME OF SIGNER		26. NAME OF SIGNER		27. NAME OF SIGNER	
28. NAME OF SIGNER		29. NAME OF SIGNER		30. NAME OF SIGNER	
31. NAME OF SIGNER		32. NAME OF SIGNER		33. NAME OF SIGNER	
34. NAME OF SIGNER		35. NAME OF SIGNER		36. NAME OF SIGNER	
37. NAME OF SIGNER		38. NAME OF SIGNER		39. NAME OF SIGNER	
40. NAME OF SIGNER		41. NAME OF SIGNER		42. NAME OF SIGNER	
43. NAME OF SIGNER		44. NAME OF SIGNER		45. NAME OF SIGNER	
46. NAME OF SIGNER		47. NAME OF SIGNER		48. NAME OF SIGNER	
49. NAME OF SIGNER		50. NAME OF SIGNER		51. NAME OF SIGNER	
52. NAME OF SIGNER		53. NAME OF SIGNER		54. NAME OF SIGNER	
55. NAME OF SIGNER		56. NAME OF SIGNER		57. NAME OF SIGNER	
58. NAME OF SIGNER		59. NAME OF SIGNER		60. NAME OF SIGNER	
61. NAME OF SIGNER		62. NAME OF SIGNER		63. NAME OF SIGNER	
64. NAME OF SIGNER		65. NAME OF SIGNER		66. NAME OF SIGNER	
67. NAME OF SIGNER		68. NAME OF SIGNER		69. NAME OF SIGNER	
70. NAME OF SIGNER		71. NAME OF SIGNER		72. NAME OF SIGNER	
73. NAME OF SIGNER		74. NAME OF SIGNER		75. NAME OF SIGNER	
76. NAME OF SIGNER		77. NAME OF SIGNER		78. NAME OF SIGNER	
79. NAME OF SIGNER		80. NAME OF SIGNER		81. NAME OF SIGNER	
82. NAME OF SIGNER		83. NAME OF SIGNER		84. NAME OF SIGNER	
85. NAME OF SIGNER		86. NAME OF SIGNER		87. NAME OF SIGNER	
88. NAME OF SIGNER		89. NAME OF SIGNER		90. NAME OF SIGNER	
91. NAME OF SIGNER		92. NAME OF SIGNER		93. NAME OF SIGNER	
94. NAME OF SIGNER		95. NAME OF SIGNER		96. NAME OF SIGNER	
97. NAME OF SIGNER		98. NAME OF SIGNER		99. NAME OF SIGNER	
100. NAME OF SIGNER		101. NAME OF SIGNER		102. NAME OF SIGNER	

BUREAU V. S.

NOV 21 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12263

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12228

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Radiant Valley		c. LENGTH OF STAY IN 1b 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Radiant Valley	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6906 Shepherd Street			d. STREET ADDRESS 6906 Shepherd Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Walter Benjamin Gordon (Gordan)			4. DATE OF DEATH Month November Day 10 Year 19 57		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1921		9. AGE (In years last birthday) 36 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Service Station		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Joseph Gordon			14. MOTHER'S MAIDEN NAME Anne Puryear		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 225-14-5987		17. INFORMANT Address Ann Gordon; same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gunshot wound of head DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted gunshot wound of head			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 11- 10-57		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Radiant Valley, Pr. Geo. Md.		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Nov. 10, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/13/1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO., Riverdale, Md.		ADDRESS		24a. REC'D BY REGISTRAR NOV 13 '57	
				24b. REGISTRAR'S SIGNATURE W. W. Chambers	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 must be retained for your files. The funeral director: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. Its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S OFFICE OF DEATH

RECEIVED
NOV 13 1957
BUREAU V. 4

Name of Deceased		Date of Death	
John J. Jones		11-11-57	
Age		Sex	
45		Male	
Race		Occupation	
White		None	
Residence		Cause of Death	
1234 Main St., Baltimore, Md.		Heart disease	
Medical History		Manner of Death	
Hypertension, Diabetes		Natural	
Previous Illnesses		Signature of Examiner	
None		J. T. Smith, M.D.	
Signature of Physician		Signature of Coroner	
None		None	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12229

12216 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>41 Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>519 Montgomery St</u>		d. STREET ADDRESS <u>519 Montgomery St</u>	
3. NAME OF DECEASED (Type or print) <u>Richard W. Grace</u>		4. DATE OF DEATH <u>November 2 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 1, 1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B&O Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles A. Grace</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Anderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>705-07-5153</u>	
17. INFORMANT <u>Mr Richard L. Grace</u>		Address <u>206 6th St Laurel Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Secondary anaemia</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma lung.</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u> <u>4 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> 19 <u>57</u> p. m. <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/2/57</u> to <u>11/2/57</u> , that I last saw the deceased alive on <u>11/2/57</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>N B Stewart</u> M.D.		ADDRESS (Street, city or town, state) <u>314 Comp Ave Laurel Md</u>	
DATE SIGNED <u>11/3/57</u>		DATE SIGNED <u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>11/5/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Northwood New Park</u>	22d. LOCATION (City, town, or county) (State) <u>Laurel, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Donaldson</u>		ADDRESS <u>Laurel Md</u>	
24a. REC'D BY REGISTRAR <u>NOV 8 57</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BATHINGORE		DATE OF DEATH 1957	
NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		OCCUPATION [Faint text]	
PLACE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]	
DATE OF SIGNATURE [Faint text]		DATE OF SIGNATURE [Faint text]	

BUREAU V. S.

NOV 8 1957

RECEIVED

12217 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. LENGTH OF STAY IN 1b 1 wk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 23 GREENBELT			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GEN. HOSP.				d. STREET ADDRESS 57 - H RIDGE ROAD			
3. NAME OF DECEASED (Type or print) First JASPER Middle (NMN) Last GREEN				4. DATE OF DEATH Month NOVEMBER Day 2 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 6-21-1904		9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Mechanic--Unemployed		10b. KIND OF BUSINESS OR INDUSTRY North Carolina		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 245-01-0620		17. INFORMANT Address Wendall Abbott--514 Ridge Rd. S.E. Wash. DC			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema. DUE TO Pleural adhesions Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Surgical absence of left lower lung lobe DUE TO (c) Bronchogenic Carcinoma with mediastinal extension </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH 1 month 1 year 1 year 1 year </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10/30/57 , 19____, to 11/2/57 , 19____, that I last saw the deceased alive on 10/2 , 19____, and that death occurred at 6/50A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Arnold A. Lear M.D. 905 Sheridan St				DATE SIGNED 11-2-57			
PHYSICIAN'S NAME (Type) ARNOLD A. LEAR, M.D. Hyattsville Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/5/1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.			
23. FUNERAL DIRECTOR'S SIGNATURE W W Chambers		ADDRESS 5801 Cleve. Ave.		24a. REC'D BY REGISTRAR DATE NOV 5 '57			
24b. REGISTRAR'S SIGNATURE [Signature]							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with information regarding the funeral, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12264

Item 8 FilmG223 12-6-57 et

CERTIFICATE OF DEATH

Reg. Dist. No. 12231

1. PLACE OF DEATH o. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <i>md</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lupedo md</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lupedo md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5713 Frolick Lane</i>		d. STREET ADDRESS <i>5713 Frolick Lane</i>	
3. NAME OF DECEASED (Type or print) <i>CATHERINE</i> First <i>GUNYON</i> Middle <i>G</i> Last <i>N</i>		4. DATE OF DEATH <i>Nov 24</i> 19 <i>57</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 5 - 1875</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	11. BIRTHPLACE (State or foreign country) <i>New York</i>
13. FATHER'S NAME <i>Harry Eckert</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>adele sidders - Lupedo md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO <i>420.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic heart disease</i> DUE TO <i>10 yrs</i> (c)			INTERVAL BETWEEN ONSET AND DEATH <i>15 min</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 1954</i> , to <i>24 Nov 1957</i> , that I last saw the deceased alive on <i>24 Nov 1957</i> , and that death occurred at <i>11:45 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John Kehoe</i> M.D.		ADDRESS (Street, city or town, state) <i>8404 CHEVERLY AVE. CHEVERLY, MD.</i>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <i>11/25/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>11/27/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln</i>	22d. LOCATION (City, town, or county) (State) <i>Colmar Manor md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>F Joseph sons Hyattsville md</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 8 '57</i>	
		24b. REGISTRAR'S SIGNATURE <i>W. Seaborn</i>	

CAITH FRIE E GRAYSON

BUREAU V. S.

DEC 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12225

12218

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 96 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. STREET ADDRESS 2653 W. Park Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HAMMACK FRANCES				4. DATE OF DEATH Nov. 26, 1957			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 25, 1910	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursing		10b. KIND OF BUSINESS OR INDUSTRY (practical)		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George A. Humphrey				14. MOTHER'S MAIDEN NAME Ida A. Widerman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 577-03-0116		17. INFORMANT Mr. Wm. H. Hammack Address Ridge Rd. Woodlawn, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pulmonary edema DUE TO 175X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized carcinomatous DUE TO Carcinoma of ovaries (c) 14 yrs							INTERVAL BETWEEN ONSET AND DEATH 48 hrs 3 yrs 14 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1953 , 19 26 , 19 57 that I last saw the deceased alive on Nov 26 , 19 57 , and that death occurred at 9:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1127 57 DATE SIGNED 1746 K H. H. W. Park-6-D							
ACTUAL SIGNATURE George H. McLean M.D.				PHYSICIAN'S NAME (Type) George H. McLean			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/30/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		22d. LOCATION (City, town, or county) (State) Randallstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons ADDRESS Catonsville, Md.				24a. REC'D BY REGISTRAR DEC 2 57		24b. REGISTRAR'S SIGNATURE Dee Smith	

RECEIVED

DEC 2 1957

BUREAU V. B.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
RACE: [illegible]
RELIGION: [illegible]
MARRIAGE: [illegible]
EDUCATION: [illegible]
OCCUPATION: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF REGISTRAR: [illegible]
DATE OF REGISTRATION: [illegible]

12219

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 W Hyattsville	
f. STREET ADDRESS 5716 30th Ave.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Hilton Last Hardy		4. DATE OF DEATH Month Nov Day 23 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 Feb 1866
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painting Contractor		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Henry Hardy		14. MOTHER'S MAIDEN NAME Louise Hilton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT William W. Hardy		Address 3901 Oglethorpe St. Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio-sclerotic heart disease (c) senile hypotension		INTERVAL BETWEEN ONSET AND DEATH 244 year year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) chronic		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) fell at home		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1957 , to Nov 23rd, 1957 , that I last saw the deceased alive on Nov 23rd, 1957 , and that death occurred at 4:10A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE T. Bergeman		DATE SIGNED 11/23/57	
PHYSICIAN'S NAME (Type) Dr. Bergeman		ADDRESS (Street, city or town, state) 4314 Gallatin Street, Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/26/1957	22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery, Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers G-Riverdale, Md.		24a. REC'D BY REGISTRAR DATE NOV 26 57	
24b. REGISTRAR'S SIGNATURE Robert			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12220

CERTIFICATE OF DEATH

12233

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 23 Greenbelt	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGE'S GENERAL		d. STREET ADDRESS 13 B Laurel Hill Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HENRY Middle C Last HART		4. DATE OF DEATH Month Nov Day 3 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 Sep 1902
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months XX Days XX Hours XX Min XX	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) National Security		10b. KIND OF BUSINESS OR INDUSTRY Gov't	
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Henry Charles Hart		14. MOTHER'S MAIDEN NAME Isabelle Key	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Elizabeth Hart		Address Greenbelt, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Occur in sub. sec. of high car acc. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6:30 PM 11/3/57 to 9:05 11/3/57 that I last saw the deceased alive on 11/3/57 , and that death occurred at 9:05 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE William C. Weintraub M.D.		ADDRESS (Street, city or town, state) 30 C Ridgely Rd, Greenbelt DATE SIGNED 11/4/57	
PHYSICIAN'S NAME (Type) William C. Weintraub		Greenbelt, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 6, 1957	
22c. NAME OF CEMETERY OR CREMATORY George Washington		22d. LOCATION (City, town, or county) (State) Hyattsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR DATE NOV 7 57	
ADDRESS Hyattsville Md.		24b. REGISTRAR'S SIGNATURE W. J. Smith	

CERTIFICATE OF DEATH

1. NAME OF DECEASED WILLIAM C. J. [illegible]		2. SEX M		3. AGE [illegible]	
4. DATE OF DEATH [illegible]		5. TIME OF DEATH [illegible]		6. PLACE OF DEATH [illegible]	
7. CAUSE OF DEATH [illegible]		8. MANNER OF DEATH [illegible]		9. SIGNATURE OF PHYSICIAN [illegible]	
10. SIGNATURE OF REGISTRAR [illegible]		11. SIGNATURE OF WITNESS [illegible]		12. SIGNATURE OF DECEASED [illegible]	
13. SIGNATURE OF DECEASED [illegible]		14. SIGNATURE OF DECEASED [illegible]		15. SIGNATURE OF DECEASED [illegible]	
16. SIGNATURE OF DECEASED [illegible]		17. SIGNATURE OF DECEASED [illegible]		18. SIGNATURE OF DECEASED [illegible]	
19. SIGNATURE OF DECEASED [illegible]		20. SIGNATURE OF DECEASED [illegible]		21. SIGNATURE OF DECEASED [illegible]	
22. SIGNATURE OF DECEASED [illegible]		23. SIGNATURE OF DECEASED [illegible]		24. SIGNATURE OF DECEASED [illegible]	
25. SIGNATURE OF DECEASED [illegible]		26. SIGNATURE OF DECEASED [illegible]		27. SIGNATURE OF DECEASED [illegible]	
28. SIGNATURE OF DECEASED [illegible]		29. SIGNATURE OF DECEASED [illegible]		30. SIGNATURE OF DECEASED [illegible]	
31. SIGNATURE OF DECEASED [illegible]		32. SIGNATURE OF DECEASED [illegible]		33. SIGNATURE OF DECEASED [illegible]	
34. SIGNATURE OF DECEASED [illegible]		35. SIGNATURE OF DECEASED [illegible]		36. SIGNATURE OF DECEASED [illegible]	
37. SIGNATURE OF DECEASED [illegible]		38. SIGNATURE OF DECEASED [illegible]		39. SIGNATURE OF DECEASED [illegible]	
40. SIGNATURE OF DECEASED [illegible]		41. SIGNATURE OF DECEASED [illegible]		42. SIGNATURE OF DECEASED [illegible]	
43. SIGNATURE OF DECEASED [illegible]		44. SIGNATURE OF DECEASED [illegible]		45. SIGNATURE OF DECEASED [illegible]	
46. SIGNATURE OF DECEASED [illegible]		47. SIGNATURE OF DECEASED [illegible]		48. SIGNATURE OF DECEASED [illegible]	
49. SIGNATURE OF DECEASED [illegible]		50. SIGNATURE OF DECEASED [illegible]		51. SIGNATURE OF DECEASED [illegible]	
52. SIGNATURE OF DECEASED [illegible]		53. SIGNATURE OF DECEASED [illegible]		54. SIGNATURE OF DECEASED [illegible]	
55. SIGNATURE OF DECEASED [illegible]		56. SIGNATURE OF DECEASED [illegible]		57. SIGNATURE OF DECEASED [illegible]	
58. SIGNATURE OF DECEASED [illegible]		59. SIGNATURE OF DECEASED [illegible]		60. SIGNATURE OF DECEASED [illegible]	
61. SIGNATURE OF DECEASED [illegible]		62. SIGNATURE OF DECEASED [illegible]		63. SIGNATURE OF DECEASED [illegible]	
64. SIGNATURE OF DECEASED [illegible]		65. SIGNATURE OF DECEASED [illegible]		66. SIGNATURE OF DECEASED [illegible]	
67. SIGNATURE OF DECEASED [illegible]		68. SIGNATURE OF DECEASED [illegible]		69. SIGNATURE OF DECEASED [illegible]	
70. SIGNATURE OF DECEASED [illegible]		71. SIGNATURE OF DECEASED [illegible]		72. SIGNATURE OF DECEASED [illegible]	
73. SIGNATURE OF DECEASED [illegible]		74. SIGNATURE OF DECEASED [illegible]		75. SIGNATURE OF DECEASED [illegible]	
76. SIGNATURE OF DECEASED [illegible]		77. SIGNATURE OF DECEASED [illegible]		78. SIGNATURE OF DECEASED [illegible]	
79. SIGNATURE OF DECEASED [illegible]		80. SIGNATURE OF DECEASED [illegible]		81. SIGNATURE OF DECEASED [illegible]	
82. SIGNATURE OF DECEASED [illegible]		83. SIGNATURE OF DECEASED [illegible]		84. SIGNATURE OF DECEASED [illegible]	
85. SIGNATURE OF DECEASED [illegible]		86. SIGNATURE OF DECEASED [illegible]		87. SIGNATURE OF DECEASED [illegible]	
88. SIGNATURE OF DECEASED [illegible]		89. SIGNATURE OF DECEASED [illegible]		90. SIGNATURE OF DECEASED [illegible]	
91. SIGNATURE OF DECEASED [illegible]		92. SIGNATURE OF DECEASED [illegible]		93. SIGNATURE OF DECEASED [illegible]	
94. SIGNATURE OF DECEASED [illegible]		95. SIGNATURE OF DECEASED [illegible]		96. SIGNATURE OF DECEASED [illegible]	
97. SIGNATURE OF DECEASED [illegible]		98. SIGNATURE OF DECEASED [illegible]		99. SIGNATURE OF DECEASED [illegible]	
100. SIGNATURE OF DECEASED [illegible]		101. SIGNATURE OF DECEASED [illegible]		102. SIGNATURE OF DECEASED [illegible]	

BUREAU A. 3

NOV 7 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

12221

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 7 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lanham	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				d. STREET ADDRESS 8709 Annapolis Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle B. Last HASKELL				4. DATE OF DEATH Month Nov Day 26 Year 19 57			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 May 1905	
9. AGE (In years lost birthday) 52 yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.		IF UNDER 24 HRS. Months 1 Days 1 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer				10b. KIND OF BUSINESS OR INDUSTRY U S Government		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Frank B. Haskell Sr				14. MOTHER'S MAIDEN NAME Elizabeth Lanham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Beulah M Haskell Lanham, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 584X surgical shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chole cystectomy and rupture of diaphragm 24 hrs DUE TO hemorrhage (c) acute cholecystitis + cholelithiasis				INTERVAL BETWEEN ONSET AND DEATH 2 1/2			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Lanham				20g. (County) Maryland		20h. (State) Md.	
21. I certify that I attended the deceased from 11-19-57 , 19 57 to 11-26 , 19 57 , that I last saw the deceased alive on 11-26 , 19 57 , and that death occurred at 7:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE T. A. Bergmann				ADDRESS (Street, city or town, state) 4314 Gallatin St Hyattsville Md			
DATE SIGNED 11/26/57							
PHYSICIAN'S NAME (Type) T. A. Bergmann				Hyattsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/29/57		22c. NAME OF CEMETERY OR CREMATORY Whitfield Cemetery		22d. LOCATION (City, town, or county) (State) Lanham, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. RECEIVED BY REGISTRAR DEC 3 57	
24b. REGISTRAR'S SIGNATURE Beulah M Haskell				DATE DEC 3 57			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1980

BUREAU V. S.

DEC 3 1957

RECEIVED

12222

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12235

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 7604 82nd Place	
3. NAME OF DECEASED (Type or print) Mary Magdeline Caroline Herrmann		4. DATE OF DEATH Month November Day 8 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1861
9. AGE (In years last birthday) 96 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John Hackenyos		14. MOTHER'S MAIDEN NAME Mary ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Frank Herrmann; Coral Hills, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic-cardiovascular disease. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED November 7, 1957	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov 12, 1957	22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery	
22d. LOCATION (City, town, or county) (State) Washington D. C.		24a. REC'D BY REGISTRAR NOV 12 '57	
23. FUNERAL DIRECTOR'S SIGNATURE F Gasch's Sons		24b. REGISTRAR'S SIGNATURE Hyattsville, Md.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. This designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12236

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> X2 Lanham, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 9409 Dubarry Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Lorraine			4. DATE OF DEATH Month November Day 14 Year 19 57		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-23-57		9. AGE (In years last birthday) yrs. 12 Months 12 Days 14 Hours 14 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *****		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Lawrence Hinkle		
14. MOTHER'S MAIDEN NAME Margaret Albright			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Lawrence Hinkle; same as # 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation DUE TO (b) Aspiration of stomach contents Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aspirated vomitus while lying in crib.			
20c. TIME OF INJURY Month, Day, Year 9.20 a.m. 11-14-57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Lanham		20g. (County) Pr. Geo.		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/18/57		22c. NAME OF CEMETERY OR CREMATORY Holy Sepulchra Cemetery	
22d. LOCATION (City, town, or county) Montgomery Pennsylvania		22e. (State) County			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR NOV 20 57	
24b. REGISTRAR'S SIGNATURE <i>Attest</i>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. This designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 20 1957

BUREAU V. 1

Angered victim wife lying in crib.

Handwritten of speech contents

Reflections

Language studies; same as 2

Language studies

Language studies

Language studies

Language studies

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12265

CERTIFICATE OF DEATH

12237

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi Md		c. LENGTH OF STAY IN 1b 4 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Adelphi, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2307 Seminole Street				d. STREET ADDRESS 1 2307 Seminole Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Dargan Last Hodge Jr.				4. DATE OF DEATH Month November Day 20 , Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 2, 1875		9. AGE (In years day birthday) yrs. 82	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Watchman		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles D. Hodge				14. MOTHER'S MAIDEN NAME ? Yarborough			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 250 07 3044		17. INFORMANT Wilmer Perkins Adelphi, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492x Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) viral pneumonia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 weeks						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of lung	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 3, 1957 , to Nov. 20, 1957 , that I last saw the deceased alive on Nov. 3, 1957 , and that death occurred at 1:15 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7206 Colesville Rd., W. Hyattsville, Md. DATE SIGNED 11/20/57							
ACTUAL SIGNATURE Leon L. Gallin, M.D.		M.D. 7206 Colesville Rd., W. Hyattsville, Md.					
PHYSICIAN'S NAME (Type) Leon L. Gallin							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/22/57		22c. NAME OF CEMETERY OR CREMATORY Staron Removal		22d. LOCATION (City, town, or county) (State) Charlotte N. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Grachevone Hyattsville Md.				24a. REC'D BY REGISTRAR DATE NOV 25 57		24b. REGISTRAR'S SIGNATURE Overman	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the Registrar prior to burial, cremation or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
DATE OF BIRTH [Faint text, possibly "1900-01-01"]		PLACE OF BIRTH [Faint text, possibly "Maryland"]	
STREET [Faint text, possibly "1000 Main Street"]		CITY [Faint text, possibly "Baltimore"]	
STATE [Faint text, possibly "Maryland"]		ZIP CODE [Faint text, possibly "21201"]	
OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
DATE OF DEATH [Faint text, possibly "1957-11-26"]		PLACE OF DEATH [Faint text, possibly "Home"]	
SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]		SIGNATURE OF WITNESS [Faint text, possibly "Jane Doe"]	
SIGNATURE OF PHYSICIAN [Faint text, possibly "Dr. John Doe"]		SIGNATURE OF CORONER [Faint text, possibly "John Doe"]	

BUREAU V. 1

NOV 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12224

CERTIFICATE OF DEATH

12238

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 16 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gladys Middle Mylena Last Holler				4. DATE OF DEATH Month Nov Day 13 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 June 1915		9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Orange County, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elick (Alex) Franklin Stokes				14. MOTHER'S MAIDEN NAME Ora Estelle Trainum			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-20-0207		17. INFORMANT Peter Holler, 8904 Rhode Island Ave., College Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure sec. to congenital hypoplasia 757.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) to the kidneys. & multiple reticular cysts DUE TO (c) infectious INTERVAL BETWEEN ONSET AND DEATH 3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sec. pneumonia - fracture left clavicle. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 30-C RIDGE RD. GREENBELT MD.				20f. (County) PRINCE GEORGES		20f. (State) MD.	
21. I certify that I attended the deceased from Apr. 7 , 19 55 , to Nov. 13 , 19 57 , that I last saw the deceased alive on Nov. 12 , 19 57 , and that death occurred at 3:50A M, from the causes and on the date stated above. ACTUAL SIGNATURE Harry Wodak ADDRESS (Street, city or town, state) 30-C RIDGE RD. GREENBELT MD. 11-13-57 DATE SIGNED Nov 13 1957 PHYSICIAN'S NAME (Type) Dr. H. Wodak							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/16/1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. R. Chambers				24a. REC'D BY REGISTRAR NOV 15 57		24b. REGISTRAR'S SIGNATURE Deborah	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUCKAU

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12266 CERTIFICATE OF DEATH

12239

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MASS.</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRADBURY PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Worcester</u> 23X2.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5413-Shadyside Ave.</u>				d. STREET ADDRESS <u>196-MAY ST</u>			
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>MARY</u> Last <u>Hosley</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 11-1882</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRACTICAL NURSE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MAINE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BENJAMIN Chesley</u>				14. MOTHER'S MAIDEN NAME <u>MARY BURNS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>021267760</u>			
				17. INFORMANT Address <u>Zibia W. Hosley - 5413-Shadyside Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> <u>Hypertensive Fibriilation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure.</u> DUE TO (c) <u>Hypertensive Arteriosclerotic Heart Disease.</u> 310.0 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Old Coronary Thrombosis 9/2/57</u> 171.0 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>9-30-1957</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <u>9-30-1957</u> to <u>Nov 30, 1957</u> , that I last saw the deceased alive on <u>Nov 29, 1957</u> , and that death occurred at <u>9:58 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>John J. Cahane</u> M.D. <u>3801 Saitland Rd S.E.</u> PHYSICIAN'S NAME (Type) <u>John J. CAHANE</u> <u>Washington D.C.</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12-2-57</u> 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY <u>Worcester, MASS.</u> 22d. LOCATION (City, town, or county) (State) 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Simmons Bros. 1661-North Hope Rd S.E.</u> 24a. REC'D BY REGISTRAR <u>Wash. D.C.</u> 24b. REGISTRAR'S SIGNATURE							

CERTIFICATE OF DEATH

NAME OF DECEASED Mary V. Jones		SEX Female	
AGE 45 Years		DATE OF BIRTH Jan 15 1880	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Housewife	
MARITAL STATUS Married		DATE OF MARRIAGE Nov 10 1905	
NAME OF SPOUSE John V. Jones		DATE OF DEATH Dec 10 1957	
PLACE OF DEATH Baltimore, Md.		TIME OF DEATH 10:30 AM	
CAUSE OF DEATH Coronary Thrombosis		MEDICAL HISTORY Hypertension, Diabetes	
PLACE OF INTERMENT St. Mary's Cemetery		NAME OF MINISTER Rev. J. G. Evans	
NAME OF FUNERAL HOME Jones & Sons		NAME OF UNDERTAKER John V. Jones	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES John V. Jones, Mary V. Jones	
SIGNATURE OF PHYSICIAN Dr. J. G. Evans		SIGNATURE OF CORONER John V. Jones	
SIGNATURE OF REGISTRAR John V. Jones		SIGNATURE OF CLERK John V. Jones	

BUREAU V. S.

DEC 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filled with the name of the deceased, the date of death, the place of death, the cause of death, and the date of burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and return them to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12225

CERTIFICATE OF DEATH

12240

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges, MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Prince Georges.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 41 Laurel.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL GEN HOSPITAL GEN HOSPITAL		d. STREET ADDRESS Laurel Md.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANK Middle M. HOWARD Last 		4. DATE OF DEATH Month 11 Day 3 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr 20 18 73
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police man		10b. KIND OF BUSINESS OR INDUSTRY Police	
11. BIRTHPLACE (State or foreign country) Wash D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John M Howard		14. MOTHER'S MAIDEN NAME Clara Conrad.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 	
17. INFORMANT Frank R Howard.		Address 1020 University Blvd E. Son.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis 20 yrs (c) Panoxysmal Hypertension 25 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Recent Virus Infection		INTERVAL BETWEEN ONSET AND DEATH 1 WK	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I attended the deceased from 6/3/45 , 19 45 , to 11/3/57 , 19 57 , that I last saw the deceased alive on 11/3 , 19 57 , and that death occurred at 10:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. M. Warren		DATE SIGNED Laurel Md 11/3/57	
PHYSICIAN'S NAME (Type) J. M. Warren			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/7/57	
22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cem		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. K. Thompson & Son		24. REGISTRAR'S SIGNATURE W. K. Thompson & Son	
ADDRESS 5732 - 1st St NW		REC'D BY REGISTRAR NOV 7 '57	

NOV 2 1967

RECEIVED

12267

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside		c. LENGTH OF STAY IN 1b 3½ months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Hillside			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6234 Marlboro Pike				d. STREET ADDRESS 6234 Marlboro Pike		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle CYRUS Last HOYLE				4. DATE OF DEATH Month November Day 17th , Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 20th, 1884		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Locomotive Engineer		10b. KIND OF BUSINESS OR INDUSTRY Retired Railroad		11. BIRTHPLACE (State or foreign country) Morgan County, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry C. Hoyle				14. MOTHER'S MAIDEN NAME Rachael Prichard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-12-9729		17. INFORMANT Address Hillside, Md. Mrs. Helen B. Smith, 6234 Marlboro Pike			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes mellitus							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown, Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11-18-57	
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 20/1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. BURIAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR DATE NOV 21 '57		24b. REGISTRAR'S SIGNATURE W.W. Chambers	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1957

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF MEDICAL EXAMINER		12. SIGNATURE OF REGISTRAR	
				</																			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12226 CERTIFICATE OF DEATH

Reg. Dist. No. 742

12242

1. PLACE OF DEATH <u>PRINCE, GEORGES</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>LELAND, MEM. HOSPITAL</u> MARYLAND				a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVERDALE, MD.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> 47X-3 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LELAND MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>D.C. VILLAGE</u>			
3. NAME OF DECEASED (Type or print) <u>LELIA</u> First Middle Last				4. DATE OF DEATH <u>Nov.</u> Month Day Year <u>28</u> 19 <u>57</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 29, 1923</u> 33 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PEOPLES DRUG</u>		11. BIRTHPLACE (State or foreign country) <u>GILES COUNTY, TENN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HORACE J. BREWER</u>				14. MOTHER'S MAIDEN NAME <u>BLANCHE O. DANIELS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>HORACE J. BREWER</u> Address <u>8709 50TH PL. COLLEGE, PK. MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Obv. hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atrophy</u> DUE TO (c) <u>9 years</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>40 years</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8-9</u> , 19 <u>56</u> to <u>11-28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-27-57</u> , 19 <u>57</u> , and that death occurred at <u>8:00</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>T. F. O'DONOVAN</u> M.D.				ADDRESS (Street, city or town, state) <u>D.C. Village</u> DATE SIGNED <u>11-29-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 30, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Henryville</u>		22d. LOCATION (City, town, or county) (State) <u>HENRYVILLE TENN.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. Washington, D.C.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DEC 2 1957</u>		24b. REGISTRAR'S SIGNATURE <u>James Seary</u>	

CERTIFICATE OF DEATH

Dr. Maloney
(Coroner) notified and
will approve

11-28-57

11-29-57
TJD

RECEIVED
DEC 2 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filled with the information required. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, and in any event within 72 hours after death, register prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

- 12227 CERTIFICATE OF DEATH

12243

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 16hrs 35 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS 4412 Greenwood Rd.			
3. NAME OF DECEASED (Type or print) First Robert Middle Eugene Last Isles				4. DATE OF DEATH Month November Day 28 Year 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Feb. 5, 1948	
9. AGE (In years lost birthday) 9 yrs.		IF UNDER 1 YEAR Months 9 Days 28 Hours 35 Min.		IF UNDER 24 HRS. Months 9 Days 28 Hours 35 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY Student		11. BIRTHPLACE (State or foreign country) Riverdale, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Martin J. Isles				14. MOTHER'S MAIDEN NAME Bertha M. Cochran			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Bertha M. Isles Address 4412 Greenwood Rd., Greenbelt, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO 196x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma DUE TO Swings tumor of leg (c) Swings tumor of leg PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Renal Sw mo. Sw mo.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 3001 Cheverly Ave., Cheverly, Md.				20g. (County) Howard		20h. (State) Md.	
21. I certify that I attended the deceased from 11-27-57 , 19 57 , to 11-28-57 , 19 57 , that I last saw the deceased alive on 11-27-57 , 19 57 , and that death occurred at 3:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3001 Cheverly Ave., Cheverly, Md. DATE SIGNED 11-28-57							
ACTUAL SIGNATURE Bertha Van Gelderen M.D.				PHYSICIAN'S NAME (Type) Bertha Van Gelderen, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/2/57		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	
22d. LOCATION (City, town, or county) Elkridge, Howard County, Md.				22e. (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO., Riverdale, Md.				ADDRESS 3001 Cheverly Ave., Cheverly, Md.		24a. REC'D BY REGISTRAR DATE DEC 3 '57	
24b. REGISTRAR'S SIGNATURE Qu...							

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

BUREAU V. S.

DEC 4 1957

RECEIVED

12191

Item 9 Film 0222 11-20-57 et

CERTIFICATE OF DEATH

12244

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt Rainier MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16 Mt Rainier MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4523 32nd st</u>		d. STREET ADDRESS <u>14523 - 32nd st</u>	
3. NAME OF DECEASED (Type or print) First <u>THORNTON</u> Middle <u>JETT</u> Last <u>JETT</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 18 1866</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER DANCING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm H. Jett</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth a. Brauer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Miller E. Jett Mt Rainier, Md</u>	
17. INFORMANT <u>Miller E. Jett</u> Address <u>Mt Rainier, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>420.0</u> DUE TO <u>ARTERIOSCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS</u> (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>INST</u> <u>over several years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>99. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>53</u> , to <u>Nov</u> , 19 <u>57</u> that I last saw the deceased alive on <u>15 Oct</u> , 19 <u>57</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Benjamin A. Miller</u> M.D. <u>3824-34 St. Mt Rainier Md</u>		DATE SIGNED <u>Nov-13-57</u>	
PHYSICIAN'S NAME (Type) <u>BENJAMIN S. MILLER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/16/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasche some Hyattsville Md</u>		24a. REC'D BY REGISTRAR <u>NOV 15 1957</u>	
ADDRESS <u>James E. Severe</u>		24b. REGISTRAR'S SIGNATURE <u>James E. Severe</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 15 1957

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12268 CERTIFICATE OF DEATH

12245

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Pri Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARDWICK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>FREDWICK DANIEL</u> First Middle Last <u>JONES</u>				4. DATE OF DEATH Month <u>NOV</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COL.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-11-80</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Charles Jones</u>				14. MOTHER'S MAIDEN NAME <u>Hanna Bruce</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Alma Jones</u>		Address <u>4923 Ind St N.E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>10 yrs</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 11</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Sept 1950</u> to <u>Nov-2 1957</u> , that I last saw the deceased alive on <u>Nov 2, 1957</u> , and that death occurred at <u>9:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. S. Hudson</u>				M.D. <u>Laurel Md.</u>		DATE SIGNED <u>Nov 2, 1957</u>	
PHYSICIAN'S NAME (Type) <u>W. S. HUDSON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11-6-57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Hammory Cemetery Washin 9th D.C.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed. E. Harris Co - 1432 You St. 7</u>				ADDRESS <u>1432 You St. 7</u>		24a. REC'D BY REGISTRAR <u>11-8-57</u>	
24b. REGISTRAR'S SIGNATURE <u>W. S. Hudson</u>							

#178

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH AND DEATH REGISTRATION DIVISION

1. NAME OF DECEASED <i>JOHN J. BROWN</i>		2. SEX <i>MALE</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>1912</i>		5. PLACE OF BIRTH <i>NEW YORK</i>	
6. DATE OF DEATH <i>1957</i>		7. PLACE OF DEATH <i>NEW YORK</i>		8. CAUSE OF DEATH <i>HEART DISEASE</i>		9. MANNER OF DEATH <i>NATURAL</i>		10. SIGNATURE OF DECEASED <i>[Signature]</i>	
11. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		12. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		13. SIGNATURE OF CLERK <i>[Signature]</i>		14. SIGNATURE OF REGISTRAR <i>[Signature]</i>		15. SIGNATURE OF WITNESS <i>[Signature]</i>	
16. SIGNATURE OF DECEASED <i>[Signature]</i>		17. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		18. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		19. SIGNATURE OF CLERK <i>[Signature]</i>		20. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
21. SIGNATURE OF WITNESS <i>[Signature]</i>		22. SIGNATURE OF DECEASED <i>[Signature]</i>		23. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		24. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		25. SIGNATURE OF CLERK <i>[Signature]</i>	
26. SIGNATURE OF REGISTRAR <i>[Signature]</i>		27. SIGNATURE OF WITNESS <i>[Signature]</i>		28. SIGNATURE OF DECEASED <i>[Signature]</i>		29. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		30. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
31. SIGNATURE OF CLERK <i>[Signature]</i>		32. SIGNATURE OF REGISTRAR <i>[Signature]</i>		33. SIGNATURE OF WITNESS <i>[Signature]</i>		34. SIGNATURE OF DECEASED <i>[Signature]</i>		35. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>	
36. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		37. SIGNATURE OF CLERK <i>[Signature]</i>		38. SIGNATURE OF REGISTRAR <i>[Signature]</i>		39. SIGNATURE OF WITNESS <i>[Signature]</i>		40. SIGNATURE OF DECEASED <i>[Signature]</i>	
41. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		42. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		43. SIGNATURE OF CLERK <i>[Signature]</i>		44. SIGNATURE OF REGISTRAR <i>[Signature]</i>		45. SIGNATURE OF WITNESS <i>[Signature]</i>	
46. SIGNATURE OF DECEASED <i>[Signature]</i>		47. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		48. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		49. SIGNATURE OF CLERK <i>[Signature]</i>		50. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
51. SIGNATURE OF WITNESS <i>[Signature]</i>		52. SIGNATURE OF DECEASED <i>[Signature]</i>		53. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		54. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		55. SIGNATURE OF CLERK <i>[Signature]</i>	
56. SIGNATURE OF REGISTRAR <i>[Signature]</i>		57. SIGNATURE OF WITNESS <i>[Signature]</i>		58. SIGNATURE OF DECEASED <i>[Signature]</i>		59. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		60. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
61. SIGNATURE OF CLERK <i>[Signature]</i>		62. SIGNATURE OF REGISTRAR <i>[Signature]</i>		63. SIGNATURE OF WITNESS <i>[Signature]</i>		64. SIGNATURE OF DECEASED <i>[Signature]</i>		65. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>	
66. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		67. SIGNATURE OF CLERK <i>[Signature]</i>		68. SIGNATURE OF REGISTRAR <i>[Signature]</i>		69. SIGNATURE OF WITNESS <i>[Signature]</i>		70. SIGNATURE OF DECEASED <i>[Signature]</i>	
71. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		72. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		73. SIGNATURE OF CLERK <i>[Signature]</i>		74. SIGNATURE OF REGISTRAR <i>[Signature]</i>		75. SIGNATURE OF WITNESS <i>[Signature]</i>	
76. SIGNATURE OF DECEASED <i>[Signature]</i>		77. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		78. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		79. SIGNATURE OF CLERK <i>[Signature]</i>		80. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
81. SIGNATURE OF WITNESS <i>[Signature]</i>		82. SIGNATURE OF DECEASED <i>[Signature]</i>		83. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		84. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		85. SIGNATURE OF CLERK <i>[Signature]</i>	
86. SIGNATURE OF REGISTRAR <i>[Signature]</i>		87. SIGNATURE OF WITNESS <i>[Signature]</i>		88. SIGNATURE OF DECEASED <i>[Signature]</i>		89. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		90. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
91. SIGNATURE OF CLERK <i>[Signature]</i>		92. SIGNATURE OF REGISTRAR <i>[Signature]</i>		93. SIGNATURE OF WITNESS <i>[Signature]</i>		94. SIGNATURE OF DECEASED <i>[Signature]</i>		95. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>	
96. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		97. SIGNATURE OF CLERK <i>[Signature]</i>		98. SIGNATURE OF REGISTRAR <i>[Signature]</i>		99. SIGNATURE OF WITNESS <i>[Signature]</i>		100. SIGNATURE OF DECEASED <i>[Signature]</i>	

BUREAU V. 2

NOV 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12246

12269

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Dist. of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Beltsville		c. LENGTH OF STAY IN 1b 14 1/2 wk.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 90 Paul Branch Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47 x-3	
d. STREET ADDRESS 1706 Jackson St., N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Greene		4. DATE OF DEATH Nov. 15 1957	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 5, 1876	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Kent Co., Delaware		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME J. J. Jones		14. MOTHER'S MAIDEN NAME Lucy Greene	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 acute heart failure (congestive) DUE TO (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pauls agitations		INTERVAL BETWEEN ONSET AND DEATH 3 days 2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1930, to Nov. 1957, that I last saw the deceased alive on July 1957, and that death occurred at 11 P. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Thomas E. Mattingly, M.D.		22a. REC'D BY REGISTRAR	
PHYSICIAN'S NAME (Type) Thomas E. Mattingly, M.D.		24. REGISTRAR'S SIGNATURE	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/19/57	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Heights, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Halleys Funeral Home		Mt. Rainier Md.	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint handwritten name]</p>		<p>2. SEX [Faint handwritten sex]</p>	
<p>3. AGE [Faint handwritten age]</p>		<p>4. DATE OF BIRTH [Faint handwritten date]</p>	
<p>5. PLACE OF BIRTH [Faint handwritten place]</p>		<p>6. OCCUPATION [Faint handwritten occupation]</p>	
<p>7. MARITAL STATUS [Faint handwritten status]</p>		<p>8. CAUSE OF DEATH [Faint handwritten cause]</p>	
<p>9. MEDICAL HISTORY [Faint handwritten history]</p>		<p>10. SIGNATURE OF PHYSICIAN [Faint handwritten signature]</p>	
<p>11. SIGNATURE OF REGISTRAR [Faint handwritten signature]</p>		<p>12. DATE OF DEATH [Faint handwritten date]</p>	
<p>13. PLACE OF DEATH [Faint handwritten place]</p>		<p>14. TIME OF DEATH [Faint handwritten time]</p>	
<p>15. SIGNATURE OF WITNESS [Faint handwritten signature]</p>		<p>16. SIGNATURE OF DECEASED [Faint handwritten signature]</p>	

BUREAU V. 31

NOV 19 1957

RECEIVED

12228

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel 41					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 314 Compston Avenue						d. STREET ADDRESS 423 Pr Geo's St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Rose V. 1 Corp						4. DATE OF DEATH Month Day Year November 20 1957					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 24 1892		9. AGE (In years lost birthday) 65 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Randolph Anderson						14. MOTHER'S MAIDEN NAME Cecelia Hopkins					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)						16. SOCIAL SECURITY NO. —		17. INFORMANT Address Mrs. Virginia Stanton Laurel Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension Heart Disease 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) asthma - asthmatic eczema change DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 days											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Hour o. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8-11-57 to 11/20/57, that I last saw the deceased alive on 11/20/57, and that death occurred at 8:00 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE J.B. Stewart M.D. 314 Compston Ave Laurel Md PHYSICIAN'S NAME (Type) K.B. STEWART											
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF 11/23/57		22c. NAME OF CEMETERY OR CREMATORY Inglewood Cemetery Laurel Maryland		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert K. Kovalsky Laurel Md						24a. REC'D BY REGISTRAR DATE NOV 26 '57		24b. REGISTRAR'S SIGNATURE			

VS A1S (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1958

Page One of Two

<p>1. NAME OF DECEASED LAST, FIRST, MIDDLE (Print or type name in full)</p>		<p>2. SEX Male <input type="checkbox"/> Female <input type="checkbox"/></p>	
<p>3. DATE OF BIRTH (Month, day, year)</p>		<p>4. PLACE OF BIRTH (City, State, Country)</p>	
<p>5. DATE OF DEATH (Month, day, year)</p>		<p>6. PLACE OF DEATH (City, State, Country)</p>	
<p>7. CAUSE OF DEATH (List all causes, beginning with immediate cause, and giving the underlying cause last)</p>		<p>8. MANNER OF DEATH Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined <input type="checkbox"/></p>	
<p>9. SIGNATURE OF PHYSICIAN (Print name and title)</p>		<p>10. SIGNATURE OF REGISTRAR (Print name and title)</p>	
<p>11. SIGNATURE OF WITNESS (Print name and title)</p>		<p>12. SIGNATURE OF DECEASED (If living, print name and title)</p>	

BUREAU V. 21

MAY 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12192 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12248

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Rainier		c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 Mount Rainier			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2901 Arundel Road				d. STREET ADDRESS 2901 Arundel Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Anne Louise Kilcullen				4. DATE OF DEATH Month Day Year November 30 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-4-12		9. AGE (In years last birthday) 45 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrative Assistant		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Middleton				14. MOTHER'S MAIDEN NAME Anne McKee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.		17. INFORMANT Address Joseph P Kilcullen; same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> November 30, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-3-1957		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home				24. RECEIVED BY REGISTRAR DEC 3 1957			
ADDRESS 3200 - B. & Ave. Mt. Rainier, Md.				24b. REGISTRAR'S SIGNATURE James Henry			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 must be retained for your files. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. This designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH - BATHING 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF
HEALTH DEPT

Form with various fields for medical examination and death certification, including sections for personal history, physical examination, and cause of death. The text is mirrored and difficult to read.

RECEIVED
DEC 4 1957
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12270 CERTIFICATE OF DEATH

Reg. Dist. No. 12249

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DIST. OF COLUMBIA b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLENN DALE		c. LENGTH OF STAY IN 1b 2 YRS 2 MOS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GLENN DALE HOSP.		d. STREET ADDRESS 3529 14th ST. N.W.	
3. NAME OF DECEASED (Type or print) First DAVID Middle (NONE) Last KILPATRICK		4. DATE OF DEATH Month 11 Day 16 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8/15/1887
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CABINET MAKER		10b. KIND OF BUSINESS OR INDUSTRY FURNITURE	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN KILPATRICK		14. MOTHER'S MAIDEN NAME CATHERINE RAMSEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or (If known) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT DECEASED		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUFFOCATION 150x DUE TO ASPIRATION FROM ESOPHAGUS-TRACHEAL FISTULA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO CARCINOMA OF ESOPHAGUS INTERVAL BETWEEN ONSET AND DEATH 0 DAYS 7 DAYS 2 MOS.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY TUBERCULOSIS; ARTERIOSCLEROTIC HEART DISEASE WITH MYOCARDIAL INFARCTION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/26, 1955 , to 11/16, 1957 , that I last saw the deceased alive on 11/16, 1957 , and that death occurred at 2 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE MOE WEISS		ADDRESS (Street, city or town, state) GLENN DALE HOSP.	
PHYSICIAN'S NAME (Type) MOE WEISS M.D.		DATE SIGNED 11/16/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/19/57	
22c. NAME OF CEMETERY OR CREMATORY Glennwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE Ronaldi Funeral Directors - 816 N. PLANE		ADDRESS	
24a. REC'D BY REGISTRAR NOV 19 57		24b. REGISTRAR'S SIGNATURE DeWitt	

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

BUREAU V. E.

NOV 19 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

77

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UNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, removal.

VS. A15ME(5)
SM 9/55

12229

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12250

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cherry		c. LENGTH OF STAY IN 1b 2 1/2 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Oxon Hill			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 15057 Dunlop St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bertha Virginia King				4. DATE OF DEATH Mar 30 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 6, 1902	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ernest T. Scott				14. MOTHER'S MAIDEN NAME Estelle Constable			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Leahy & Pettit Address 19 Southway Greenbelt, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 971.6 DUE TO Sepsis, toxic (b) Toxic Gastritis (c) Sodium Fluoride Poisoning PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) (b) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Inhalation a solution of roach poison			
20c. TIME OF INJURY Hour o. m. 11-30 1957		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Oxon Hill (County) Prince Georges (State) Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES I. BOYD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec 1, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-4-57		22c. NAME OF CEMETERY OR CREMATORY Washington Natl. Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers & Co. 517-112 S. D. E.				24a. REC'D BY REGISTRAR DATE DEC 3 '57		24b. REGISTRAR'S SIGNATURE J. L. Smith	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 4 1957
BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12230

CERTIFICATE OF DEATH

12251

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Edmonston			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS 4801 51st Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Boy Middle Krumpe Last Krumpe				4. DATE OF DEATH Month November Day 10 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-9-57	
9. AGE (In years last birthday) yrs. 1		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 57		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Curt Krumpe				14. MOTHER'S MAIDEN NAME Thelma Hause			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 11-1-57		17. INFORMANT Mother Address as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Cerebral asphyxia DUE TO Prematurity (31 weeks gestation) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 31 weeks gestation DUE TO (c) 31 weeks gestation INTERVAL BETWEEN ONSET AND DEATH 18 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 18 hrs.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11/9 , 19 57 , to 11/10 , 19 57 ; that I last saw the deceased alive on 11/10 , 19 57 ; and that death occurred at 4:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2015 R St., N. W., Washington, D.C. DATE SIGNED 11/10/57							
ACTUAL SIGNATURE Francis Warren				M.D. 2015 R St., N. W., Washington, D.C.			
PHYSICIAN'S NAME (Type) Dr. Francis Warren							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12/1/57		22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Chesley, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr., Administrator				24a. REC'D BY REGISTRAR DATE DEC 9 '57		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John A. Smith</i></p>		<p>2. SEX <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female</p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF DEATH <i>Dec 8 1957</i></p>	
<p>5. PLACE OF DEATH <i>Home</i></p>		<p>6. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>7. PLACE OF BIRTH <i>Massachusetts</i></p>		<p>8. OCCUPATION <i>Teacher</i></p>	
<p>9. MARITAL STATUS <input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced</p>		<p>10. SIGNATURE OF DECEASED <i>John A. Smith</i></p>	
<p>11. SIGNATURE OF WITNESS <i>John A. Smith</i></p>		<p>12. SIGNATURE OF PHYSICIAN <i>John A. Smith</i></p>	
<p>13. SIGNATURE OF REGISTRAR <i>John A. Smith</i></p>		<p>14. SIGNATURE OF DECEASED <i>John A. Smith</i></p>	

BUREAU V. 3

DEC 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12231

CERTIFICATE OF DEATH

13490

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) ON INSTITUTION Prince Georges General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Seat Pleasant,			
f. STREET ADDRESS 7033 Georges Palmer Highway,				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Lanham "A"				4. DATE OF DEATH Month Day Year November 30, 1957			
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-29-57	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Leonard Lanham				14. MOTHER'S MAIDEN NAME Gladys Marie Strickland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother		Address as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelous Faint 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumatury DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Washington, D.C.		(County) D.C.	(State) D.C.
21. I certify that I attended the deceased from 11/29/57 , 19 57 to 11/30/57 , 19 57 that I last saw the deceased alive on 11/30/57 , 19 57 and that death occurred at 2:14 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1723 M St NW Washington, D.C. DATE SIGNED 12/2/57							
ACTUAL SIGNATURE Jorge Labarraque		PHYSICIAN'S NAME (Type) JORGE LABARRAQUE					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12/5/57		22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr., Administrator				24. REC'D BY REGISTRAR DEC 10 57			

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RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12271

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12252

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi		c. LENGTH OF STAY IN lb 3½ mos.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7950 18th Avenue			d. STREET ADDRESS 7950 18th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Howard Middle Jeffery Last Lawrence			4. DATE OF DEATH Month November Day 20 Year 1957		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1957		9. AGE (in years last birthday) yrs. 5 Months 5 Days 5 Hours 5 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *****		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Dist. of Columbia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Howard Pharis Lawrence		
14. MOTHER'S MAIDEN NAME Betty Allen			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Howard Lawrence; same as # 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Compression 330x DUE TO Conditions, if any, which gave rise to immediate cause (b) Subdural and subarachnoid hemorrhage (c) Subdural and subarachnoid hemorrhage DUE TO (a) stating the underlying cause last. (c) Subdural and subarachnoid hemorrhage					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown			
20c. TIME OF INJURY Month, Day, Year Hour Unknown 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unknown	
20f. (City or town) Unknown		20g. (County) Unknown		20h. (State) Unknown	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED November 20, 1957	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/22/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
22d. LOCATION (City, town, or county) Colmar Manor, Md.		22e. (State) Md.		22f. (Country) U.S.A.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.			24a. REC'D BY REGISTRAR Nov 25 57		
24b. REGISTRAR'S SIGNATURE Maloney			24c. (City or town) Hyattsville, Md.		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. 4. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, of its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BATHING
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

357

THE STATE
MOUNTAIN DEPT.

1. Name of deceased Mary Jane	2. Sex Female	3. Age 35 mos.	4. Race Caucasian	5. Date of death Nov. 26, 1957	6. Place of death 1824 Avenue
7. Cause of death Infantile	8. Manner of death Natural	9. Signature of physician Howard H. Lawrence	10. Signature of medical examiner Robert Allen	11. Date of death Nov. 26, 1957	12. Place of death 1824 Avenue

RECEIVED

General Commission
H. H. Lawrence and Robert Allen

BUREAU A. 5

NOV 26 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville (Lewisdale)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville (Lewisdale)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2201 Beechwood Road		d. STREET ADDRESS 2201 Beechwood Road	
3. NAME OF DECEASED (Type or print) First Middle Last Nellie Rosalia Lee		4. DATE OF DEATH Month Day Year Nov 30 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1888
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John A. Sunderland	
14. MOTHER'S MAIDEN NAME Anna Geyer		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. No		17. INFORMANT Address Rosalia Jones - 2201 Beechwood Road Hyattsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Rectum with 154x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) widespread metastases DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1957, to Nov 30, 1957, that I last saw the deceased alive on Nov 30, 1957, and that death occurred at 1:57 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard L. Whelton M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 1021 University Blvd E Langley Park Silver Spring Md	
PHYSICIAN'S NAME (Type) Richard L. Whelton		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 12/4/57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St. N.W. Washington, D.C.	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE James Seery	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

REC 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12181

CERTIFICATE OF DEATH

Item 9 Film G-231, 7-10-58, EJ

12254

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Pr Geo</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>P.G.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>same</u>			
c. LENGTH OF STAY IN 1b <u>6 mos</u>				d. STREET ADDRESS <u>same</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9022 45th St</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FANNIE LOFLIN</u>				4. DATE OF DEATH Month Day Year <u>NOV 8 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 5, 1874</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William Nelson Morris</u>				14. MOTHER'S MAIDEN NAME <u>? --- Riley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>James Loflin</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct 15, 1957</u> , to <u>NOV 8, 1957</u> , that I last saw the deceased alive on <u>11-28-57</u> , and that death occurred at <u>12 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. L. Etienne</u>				ADDRESS (Street, city or town, state) <u>4713 Bevers Rd</u>			
PHYSICIAN'S NAME (Type) <u>W. L. Etienne College Park, Md</u>				DATE SIGNED <u>11-8-57</u>			
22a. BURIAL, CREMATION, REMOVAL, etc. <u>Transportation</u>		22b. DATE THEREOF <u>Nov 8, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Thomasville</u>		22d. LOCATION (City, town, or county) (State) <u>North Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Maschio Sons.</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov 12 57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. H. Smith</u>			

MAJOR AND STATE DEPARTMENT OF HEALTH—BATHING MORE

15136 • J. Neurosci., September 24, 2008 • 28(39):15130–15136

NOV 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12232

CERTIFICATE OF DEATH

Reg. Dist. No.

12255

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Mayrland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 14 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphia	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 2708 Hughes Rd			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last "B" MARKER				4. DATE OF DEATH Month Nov Day 29 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 Nov 1957		9. AGE (In years last birthday) yrs. 14	IF UNDER 1 YEAR Months 14 Days 14 Hours 14 Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Garland Marker				14. MOTHER'S MAIDEN NAME Theresa Ann Wiedel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Frederick Marker		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abnormal pulmonary ventilation 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity (Feb 12g) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:30A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas A. Chrintzman M.D.				ADDRESS (Street, city or town, state) College Park Rd		DATE SIGNED 11/29/57	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/30/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons				ADDRESS 4739 Baltimore Ave. Hyattsville, Md.		24a. REC'D BY REGISTRAR DEC 3 57	
				24b. REGISTRAR'S SIGNATURE Qu...			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000

DEC 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.
TO REGISTRAR: The law requires that the death certificate be executed within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12256

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6610-23rd Place</u>		d. STREET ADDRESS <u>6610-23rd Place</u>	
3. NAME OF DECEASED (Type or print) <u>Catherine</u> First Middle Last <u>Martin</u>		4. DATE OF DEATH Month <u>11</u> - Day <u>17</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/8/1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Carbondale, Pa.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Dominic Carvinton</u>		14. MOTHER'S MAIDEN NAME <u>Mary Coggins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Michael Horman</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, general</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>54</u> , to <u>Nov 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 17</u> , 19 <u>57</u> , and that death occurred at <u>11:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John F. Brennan Jr.</u> M.D. <u>3425 12th St, N.E.</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>JOHN F. BRENNAN JR., M.D.</u>		<u>Washington 17, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/21/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Rose Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Carbondale, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malloy Funeral Home</u> ADDRESS <u>Mt. Rainier</u>		24a. REC'D BY REGISTRAR <u>NOV 19 1957</u> 24b. REGISTRAR'S SIGNATURE <u>James C. ...</u>	

BUREAU V. S.

NOV 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12233

CERTIFICATE OF DEATH

Reg. Dist. No.

12257

1. PLACE OF DEATH o. COUNTY PRINCE GEORGE'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGE'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY KIXORE		c. LENGTH OF STAY IN 1b 2 Mo 17 Da	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGE'S GENERAL		d. STREET ADDRESS 419 Main St.	
3. NAME OF DECEASED (Type or print) ELEANOR		4. DATE OF DEATH Month NOV Day 21 Year 1957	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 Nov 1873
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John T. Baldwin		14. MOTHER'S MAIDEN NAME Frances Delles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. H. B. Mayo Sr.		Address 102 West Towne, Baltimore	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 31, 1957 , to 21 Nov, 1957 , that I last saw the deceased alive on 21 Nov, 1957 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John Keehoe M.D.			
PHYSICIAN'S NAME (Type) Dr. John Keehoe			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 25, 1957	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC.		ADDRESS Baltimore Md.	
24a. REC'D BY REGISTRAR NOV 25 57		24b. REGISTRAR'S SIGNATURE Dee Beach	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BUREAU V. S.

NOV 25 1957

RECEIVED

12234 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINLE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY PRINLE GEORGE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL		c. LENGTH OF STAY IN 1b adm. April 27-56		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UPPER MARRBORO X2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM				d. STREET ADDRESS Box 96		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAUDE Middle A. M. Last MANUS				4. DATE OF DEATH Month 11 Day 22 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-5-1866		9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB A. AMBLER				14. MOTHER'S MAIDEN NAME MARK ANN STEELE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. none		17. INFORMANT HOSPITAL RECORDS LAUREL SANITARIUM Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral vascular accident 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cerebral arteriosclerosis with psychotic reaction DUE TO (c) many years						INTERVAL BETWEEN ONSET AND DEATH 2 days ago	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic arthritis of the left hip and the left knee						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 7 , 19 56 , to Nov. 22 , 19 57 , that I last saw the deceased alive on Nov-22- , 19 57 , and that death occurred at 945 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Erika P. Kramer		M.D. Laurel Sanitarium		ADDRESS (Street, city or town, state) Laurel Md.		DATE SIGNED 11-22-57	
PHYSICIAN'S NAME (Type) ERIKA P. KRAMER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/25/57		22c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery		22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home-Marlboro, Md.				ADDRESS Upper		24a. REC'D BY REGISTRAR NOV 27 57	
				24b. REGISTRAR'S SIGNATURE Paul			

BUREAU V. S.

2967 25 AUG.

RECEIVED

12235

12259

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

NOV 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 19 1957

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12236

CERTIFICATE OF DEATH

12261

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE DISTRICT OF COLUMBIA b. COUNTY.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON D.C. 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) LAUREL SANITARIUM		d. STREET ADDRESS 2853 ONTARIO ROAD N.W.	
3. NAME OF DECEASED (Type or print) MARY First EFFIE Middle NETHERLAND Last		4. DATE OF DEATH Nov. 23 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 22-1866
9. AGE (In years last birthday) 91 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM A. DEITRICK		14. MOTHER'S MAIDEN NAME MARY LOUISE MOODY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT HOSPITAL RECORDS LAUREL SANITARIUM		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ventricular fibrillation 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic cardio-vascular disease DUE TO (c) many years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome assoc. with cerebral arteriosclerosis with psychotic reaction			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug-9- , 19 56 , to Nov. 23 , 19 57 , that I last saw the deceased alive on Nov. 23- , 19 57 , and that death occurred at 11:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Linda P. Kramer		ADDRESS (Street, city or town, state) LAUREL SANITARIUM Nov-23-1957	
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER		DATE SIGNED LAUREL MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV. 26/57	
22c. NAME OF CEMETERY OR CREMATORY HOLLYWOOD CEM.		22d. LOCATION (City, town, or county) (State) RICHMOND, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hyson		24a. REC'D BY REGISTRAR NOV 25 57	
ADDRESS WASH. D.C. 1300-N ST. N.W.		24b. REGISTRAR'S SIGNATURE W. H. Beach	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED MARY E. BROWN</p>		<p>2. SEX F</p>	
<p>3. AGE 65</p>		<p>4. DATE OF BIRTH 1890</p>	
<p>5. PLACE OF BIRTH BOSTON, MASS.</p>		<p>6. OCCUPATION HOUSEWIFE</p>	
<p>7. MARITAL STATUS MARRIED</p>		<p>8. DATE OF MARRIAGE 1915</p>	
<p>9. NAME OF SPOUSE JOHN B. BROWN</p>		<p>10. DATE OF DEATH 1957</p>	
<p>11. PLACE OF DEATH HOME</p>		<p>12. CAUSE OF DEATH HEART DISEASE</p>	
<p>13. MEDICAL HISTORY HYPERTENSION</p>		<p>14. SIGNATURE OF PHYSICIAN J. B. BROWN</p>	
<p>15. SIGNATURE OF REGISTRAR J. B. BROWN</p>		<p>16. DATE OF REGISTRATION 1957</p>	

BUREAU V. S.

NOV 25 1957

RECEIVED

12237 CERTIFICATE OF DEATH

12263

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 3 Hrs 55 Min 38			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			
d. STREET ADDRESS 2815 Laurel Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ORSINI, Middle BABY BOY Last				4. DATE OF DEATH Month Nov Day 26 Year 19 57			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 26 Nov 1957	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours 3 Min. 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Robert Joseph Orsini				14. MOTHER'S MAIDEN NAME Virginia Ruth Keith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mother Address as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity 774x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Premature Labor (5 1/2 mo.) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11/26 , 19 57 , to 11/26/ , 19 57 , that I last saw the deceased alive on 11/26/ , 19 57 , and that death occurred at 9:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 11/27/57 DATE SIGNED ACTUAL SIGNATURE Albert S. Robins M.D. 2025 Eye St NW Wash. D.C.							
PHYSICIAN'S NAME (Type) Albert S. Robins				11/27/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12/1/57		22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harty G. Penn, Jr., Administrator ADDRESS				24a. REC'D BY REGISTRAR DATE DEC 9 '57		24b. REGISTRAR'S SIGNATURE W. L. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2277265XVO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12273

CERTIFICATE OF DEATH

Reg. Dist. No. 12264

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PALMER PARK</u>				c. LENGTH OF STAY IN 1b <u>4 MONTHS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8200 Muncy Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WAYNE</u> Middle <u>(M.M.N.)</u> Last <u>OSBORNE</u>				4. DATE OF DEATH Month <u>NOV</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 8/1970</u>	9. AGE (In years lost birthday) <u>87</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STATIONARY ENGINEER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOTEL</u>		11. BIRTHPLACE (State or foreign country) <u>WAYNE COUNTY, W. VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JOHN OSBORNE</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT Address <u>JACOB V. OSBORNE, 8200 Muncy Rd Palmer Park, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease?</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>instantaneous</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. <u>9</u> p. m. Month, Day, Year <u>19</u>			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Oct 4, 1957</u> , to <u>November 4, 1957</u> , that I last saw the deceased alive on <u>November 4, 1957</u> , and that death occurred at <u>8:00</u> M., from the cause and on the date stated above.							
ACTUAL SIGNATURE <u>William D. Rosson MD</u>				ADDRESS (Street, city or town, state) <u>5304 Annapolis Rd. Bladensburg, MD</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM D. ROSSON, M.D.</u>				DATE SIGNED _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WASH NATL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SMITHMD, R 600 Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS Co - RIVERDALE, MD</u>				24a. REC'D BY REGISTRAR <u>DEC 3 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u>	

12274 CERTIFICATE OF DEATH

12265

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. 2 - Box 251</u>		e. IS RESIDENCE ON A FARM <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>H</u> Last <u>PATE</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 13 - 1910</u>
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OKLAHOMA</u>	
11. BIRTHPLACE (State or foreign country) <u>OKLAHOMA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Robert F. Pate</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>MARGARET I. Pate</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver Failure - Neglect coma</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cirrhosis</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u> <u>you</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 1956</u> to <u>Nov. 20, 1957</u> , that I last saw the deceased alive on <u>Nov. 20, 1957</u> , and that death occurred at <u>8:13 M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard H. Dobson</u> M.D.		ADDRESS (Street, city or town, state) <u>Brandywine, md.</u>	
PHYSICIAN'S NAME (Type) <u>Richard H. Dobson</u>		DATE SIGNED <u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 22-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl.</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sammons Bros.</u>		24a. REC'D BY REGISTRAR <u>1661-1000 Hope Rd SE</u>	24b. REGISTRAR'S SIGNATURE <u> </u>
ADDRESS <u>W. Ash. D.C.</u>		DATE <u>NOV 21 '57</u>	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12275

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12268

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Hills		c. LENGTH OF STAY IN 1b 3 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4202 70th Ave.		e. STREET ADDRESS 4202 70th Ave.	
3. NAME OF DECEASED (Type or print) RUFUS		4. DATE OF DEATH Nov. 5, 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-16-09
9. AGE (in years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic		12. KIND OF BUSINESS OR INDUSTRY Pontiac Co.	
13. BIRTHPLACE (State or foreign country) West Virginia		14. CITIZEN OF WHAT COUNTRY U.S.A.	
15. FATHER'S NAME Charles William Penwell		16. MOTHER'S MAIDEN NAME Virgie Smallwood	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		18. SOCIAL SECURITY NO. 235-12-1001	
19. INFORMANT Margaret E. Penwell		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) Cardiovascular renal disease DUE TO (c) Conditions, if any, which gave rise to immediate cause [a], stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED November 6, 1957	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/9/57	22c. NAME OF CEMETERY OR CREMATORY New Norborne	22d. LOCATION (City, town, or county) (State) Martinsburg W.Va.
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. Brown		24. REC'D BY REGISTRAR NOV 12 57	
ADDRESS Martinsburg W.Va.		24b. REGISTRAR'S SIGNATURE Paul...	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health. The designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Place of Birth		Sex		Age		Date of Death	
JAMES H. HARRIS		BALTIMORE, MD.		Male		31 Years		JANUARY 11, 1957	
Occupation		Cause of Death		Manner of Death		Place of Death		Date of Burial	
None		Heart Disease		Natural		Home		JANUARY 12, 1957	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer		Signature of Witness	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

NOV 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.
Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12276

CERTIFICATE OF DEATH

Reg. Dist. No.

12267

1. PLACE OF DEATH COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD 6. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAK CREST		c. LENGTH OF STAY IN 1b Oak Crest x0	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OLIVER Middle J Last PETWAY		4. DATE OF DEATH Month Nov Day 18 Year 1957	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11/1880
9. AGE (In years lost birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. BIRTHPLACE (State or foreign country) Nashville Tenn
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Henry Petway	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 213-16-2225		17. INFORMANT Johnnie Petway Address Oak Crest	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac failure DUE TO (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 1 day sev. yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. 11 Month 19 Day 19 Year 1957 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/18/57 , 19 57 to 11/18/57 , that I last saw the deceased alive on 11/18/57 , 19 57 , and that death occurred at 10 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Harold H. H. H.		PHYSICIAN'S NAME (Type) Harold H. H. H.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 21, 1957	
22c. NAME OF CEMETERY OR CREMATORY Bacon's Chapel		22d. LOCATION (City, town, or county) (State) Anne Arundel Md	
23. FUNERAL DIRECTOR'S SIGNATURE Ridgley Selby		24. REC'D BY REGISTRAR Nov 22 57	
ADDRESS 401 Wash. Ave. Laurel		24b. REGISTRAR'S SIGNATURE W. H. H.	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12277

CERTIFICATE OF DEATH

12268

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo's Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill, Maryland		c. LENGTH OF STAY IN 1b 2 Years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Oxon Hill, Maryland		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
d. STREET ADDRESS 5616- Bock Terrace S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EMEDIO First Middle Last PONZIANO		4. DATE OF DEATH Nov. 27th. 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 5th. 1876
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Stone Cutter	
11. BIRTHPLACE (State or foreign country) Teramo, Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ponziano Ponziano		14. MOTHER'S MAIDEN NAME Unk.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Theresa Ponziano		Address Same # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate with metastasis. 177X DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 1956, to Nov. 25, 1957, that I last saw the deceased alive on Nov 25, 1957, and that death occurred at 12:40 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Etienne Szollosi		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) Dr. Etienne Szollosi		M.D. Dr. Etienne Szollosi S.E.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 29-57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers		24. REC'D BY REGISTRAR 1601- Good Hope Rd. Washington 20, D.C. DEC 2 1957	
24b. REGISTRAR'S SIGNATURE Darnie Campbell			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.
page 1 and 2 should be filled with
information regarding the burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12239

CERTIFICATE OF DEATH

12270

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Pr. George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>41 Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>318 Prince George</u>		d. STREET ADDRESS <u>318 Prince George St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jennings B. Reelley</u>		4. DATE OF DEATH Month Day Year <u>November 20 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 30 1908</u>
9. AGE (In years last birthday) <u>49 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>superintendent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Daniel Reelley</u>		14. MOTHER'S MAIDEN NAME <u>Anna May Garrison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MISSING</u>	
17. INFORMANT <u>Mrs Laine Reelley</u>		Address <u>Laurel Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410X Acute Cardiac Failure</u> DUE TO (b) <u>Myocardial + Pulmonary Disease</u> DUE TO (c) <u>Myocardial + Pulmonary Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3:14</u> , 19 <u>57</u> , to <u>14:30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/20</u> , 19 <u>57</u> , and that death occurred at <u>10:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W B Stewart</u>		DATE SIGNED <u>11/27/57</u>	
PHYSICIAN'S NAME (Type) <u>W B Stewart</u>		ADDRESS <u>314 Conklin Ave Laurel Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/23/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Long Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Heather Donahoe</u>		ADDRESS <u>Laurel Md</u>	
24. REC'D BY REGISTRAR <u>W B Stewart</u>		24b. REGISTRAR'S SIGNATURE <u>W B Stewart</u>	
DATE <u>NOV 26 57</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12238

CERTIFICATE OF DEATH

12269

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Georgia</i> b. COUNTY <i>Richmond</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesley</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Augusta</i> <i>49X-3</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince Georges Gen Hospital</i>				d. STREET ADDRESS <i>1105 8th St.</i>			
3. NAME OF DECEASED (Type or print) First <i>Georgia</i> Middle Last <i>Ratford</i>				4. DATE OF DEATH Month <i>Nov</i> Day <i>4</i> Year <i>1957</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2/8/94</i>	
9. AGE (In years last birthday) <i>83</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Augusta GA</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>							
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <i>Marion Sullivan</i> Address <i>7263 Geo. Palmer</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arteriosclerosis</i> DUE TO (c) <i>Unknown</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>11/4</i> , 19 <i>57</i> , to <i>11/4</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>11/4</i> , 19 <i>57</i> , and that death occurred at <i>6:30 P</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>John T. Ryan</i>				ADDRESS (Street, city or town, state) <i>5241 St. Barnabas Rd N.W. 21 D</i>			
PHYSICIAN'S NAME (Type) <i>H. F.</i>				DATE SIGNED <i>11/5/57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>11-7-57</i>				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State) <i>Augusta Georgia</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry S. Washington</i>				ADDRESS <i>467 N. St. N.W.</i>			
24a. REC'D BY REGISTRAR <i>Nov 8 '57</i>				24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12188 CERTIFICATE OF DEATH

Reg. Dist. No.

12271
245

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		c. LENGTH OF STAY IN 1b 9 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOME		d. STREET ADDRESS 4005 13th. Street, N. E.	
3. NAME OF DECEASED (Type or print) First MARGARET Middle T. Last RICHARDS		4. DATE OF DEATH Month NOV. Day 15, Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 25, 1870 87 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) IRELAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM FLEMING		14. MOTHER'S MAIDEN NAME CATHERINE FLEMING	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT DELLA DONOHUE Address WASH. 3413 WISC. AVE. N.W. D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) generalized Arterio Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 3/29/57 20 years 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/29/57 , 19____, to 11/15/57 , 19____, that I last saw the deceased alive on 11/9/57 , 19____, and that death occurred at 9:20 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John J. Sweeney, MD		ADDRESS (Street, city or town, state) 1238 Mich. Ave. N.E. Washington, D.C.	
DATE SIGNED 11/15/57			
PHYSICIAN'S NAME (Type) John J. Sweeney, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-18-57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins ADDRESS Wash. D.C. 3821 14th. St. N.W.		24a. REC'D BY REGISTRAR Nov 17 1957 24b. REGISTRAR'S SIGNATURE Mrs. Jan Severe	

CERTIFICATE OF DEATH

NAME OF DECEASED MARGARET		DATE OF BIRTH 1895	
RESIDENCE BALTIMORE, MARYLAND		OCCUPATION HOUSEWIFE	
DATE OF DEATH NOV 19 1957		PLACE OF DEATH HOME	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. J. SURGEY MD		SIGNATURE OF WITNESSES J. J. SURGEY MD	
SIGNATURE OF REGISTRAR J. J. SURGEY MD		SIGNATURE OF CLERK J. J. SURGEY MD	

BUREAU V. 2

NOV 19 1957

RECEIVED

11/5/57

Dr Maloney notified regarding the death of this patient

John J. Surgery MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12278 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12272

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. **FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. This designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ritchie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x 2 Ritchie	
c. LENGTH OF STAY in 1b 12 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7100 Ritchie Road		d. STREET ADDRESS 7100 Ritchie Road	
3. NAME OF DECEASED (Type or print) Paul Clayton Shegogue		4. DATE OF DEATH Nov. 11 1957	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-17-98
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY R.R.Express	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James H. Shegogue		14. MOTHER'S MAIDEN NAME Mollie ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Nellie Shegogue; Same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral compression 331x DUE TO Conditions, if any, which gave rise to immediate cause (b) Spontaneous intracranial hemorrhage (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. M. loney		DATE SIGNED	
EXAMINER'S NAME (Type) John T. M loney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> November 11, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/15/57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home-Marlboro, Md.		24a. REC'D BY REGISTRAR Nov 18 57	24b. REGISTRAR'S SIGNATURE Aw. Lewis

STATE OF NEW YORK
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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BUREAU V. E.

NOV 18 1957

RECEIVED

12240 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Pg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md		c. LENGTH OF STAY IN 1b 15 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Owens, Md			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ellis Silverstone				4. DATE OF DEATH Month Day Year Nov. 28 1957			
5. SEX Male	6. COLOR OR RACE W Jewish	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Liverpool, England		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gedalia Silverstone				14. MOTHER'S MAIDEN NAME Rebecca Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Wife		Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> Bilateral Hydrothorax 24 hrs. DUE TO <u>Uremia</u> Bilateral Hydropneumothorax + Hydronephrosis, 6 mos. DUE TO <u>Benign Prostatic Hypertrophy</u> ? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/13 1957, to 11/28 1957, that I last saw the deceased alive on 11/28 1957, and that death occurred at 12:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Louis B. Bachrach M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 915 - 14 St. N.W. Wash. D.C. 11/28/57			
PHYSICIAN'S NAME (Type) LOUIS B. BACHRACH M.D.							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/29/57		22c. NAME OF CEMETERY OR CREMATORY Friendship Lodge Cemetery		22d. LOCATION (City, town, or county) (State) Hyattsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Wagnersky				ADDRESS 3501 - 14 St. N.W.		24a. REC'D BY REGISTRAR DATE DEC 2 '57	
				24b. REGISTRAR'S SIGNATURE W. Leach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 100, 101

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		35		M		W		1890		MASSACHUSETTS	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
100 N. BOSTON ST.		LABORER		8 YEARS		MARRIED		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN	
DEC 1 1957		BOSTON		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES		JAMES J. JONES	
DATE OF BURIAL		PLACE OF BURIAL		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CITY OF BURIAL	
DEC 2 1957		BOSTON		BOSTON		MASSACHUSETTS		UNITED STATES		BOSTON	

BUREAU V. S.

DEC 2 1957

RECEIVED

BALTIMORE, 18

12279

CERTIFICATE OF DEATH

Reg. Dist. No.

12274
243

1. PLACE OF DEATH a. COUNTY Pr. Geo's. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Harold -- Slingluff				4. DATE OF DEATH Month November Day 29 Year 57.			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1884	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min.	IF UNDER 24 HRS. Months 73 Days 73 Hours 73 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postmaster-Gen. Farming-Own Farm		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Truman Cross Slingluff				14. MOTHER'S MAIDEN NAME Florence Hardesty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Marion Slingluff-Mitchellville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Paralysis Agitans 450.0 DUE TO Arteriosclerosis 10 yr							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Secondary Anemia 1 yr							
(c) Uremia							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from Jan 1, 1955 , to Nov. 29, 1957 , that I last saw the deceased alive on Nov. 29, 1957 , and that death occurred at 9:10 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE James G. Sasser M.D.				DATE SIGNED Upper Marlboro Md. 11-29-57			
PHYSICIAN'S NAME (Type) James G. Sasser, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/2/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Oak Cemetery		22d. LOCATION (City, town, or county) (State) Mitchellville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.				24a. REC'D BY REGISTRAR DEC 4 1957			
24b. REGISTRAR'S SIGNATURE Agnes Young							

DEC 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12275

12241 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Herbert Sherman Smith		4. DATE OF DEATH Month Nov Day 17 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 Sept. 1914
9. AGE (In years last birthday) 43 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Manager	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Manager		10b. KIND OF BUSINESS OR INDUSTRY Hospital	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Herbert Henry Smith		14. MOTHER'S MAIDEN NAME Mary Mullin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs Helen A Smith		Address College Park, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Hydrothorax. Pulmonary edema 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure. DUE TO (c) Hypertensive Cardiovascular Renal Disease		INTERVAL BETWEEN ONSET AND DEATH 1 week 1 week years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1946 , 19 Nov , 19 57 , that I last saw the deceased alive on 18 Nov 57 , and that death occurred at 6,50A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 4713-Berwyn Rd College Park, Md. DATE SIGNED 11/18/57	
ACTUAL SIGNATURE Dr. Etienne		M.D. College Park, Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/20/57	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR NOV 20 '57		24b. REGISTRAR'S SIGNATURE W. L. ...	

1957 02 AGM

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12242 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12276

Items 11, 12, 13, 14 Film G222 11-18-57 et

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. His designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b D.O.A.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Moses Smith			4. DATE OF DEATH Nov. 7, 19 57		
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1899		9. AGE (in years last birthday) 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		November 7, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-15-1957	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John T. Rhines & Co. 901 3rd Street, S. W.		24a. REC'D BY REGISTRAR NOV 14 '57		24b. REGISTRAR'S SIGNATURE <i>W. H. Smith</i>	

RECEIVED

NOV 14 1957

BUREAU V. S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH		STATE OF MARYLAND	
Name of Deceased		John T. Talmer, Jr.	
Date of Death		November 14, 1957	
Place of Death		Home	
Cause of Death		Acute myocardial infarction	
Manner of Death		Natural	
Signature of Medical Examiner		[Signature]	
Signature of Coroner		[Signature]	
Signature of Registrar		[Signature]	

12189 12189 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12277

1. PLACE OF DEATH a. COUNTY <u>Prince Geo.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4716 - 66 Pl. PARKWAY Estates</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Harvey</u> Last <u>Styron</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 21, 1886</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u> Hours <u>19</u> Min.	IF UNDER 24 HRS. Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auditor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>William Finley Styron</u>			
14. MOTHER'S MAIDEN NAME <u>Elva Davis</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>216-30-3908</u>				17. INFORMANT <u>ADA R. STYRON - 4716-66 Pl</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Gall Bladder</u> DUE TO (c) <u>4716 Arteriosclerotic Cardiovascular Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>20 hours</u> <u>4 Months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4716 Arteriosclerotic Cardiovascular Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>3130 N 10th St Arlington, Va.</u>	
20f. (City or town) <u>Morehead City N.C.</u>				20g. (County) <u>Currituck</u>			
21. I certify that I attended the deceased from <u>JUNE</u> , 1957, to <u>Nov 6</u> , 1957, that I last saw the deceased alive on <u>Nov 5</u> , 1957, and that death occurred at <u>3:15 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James R. McCalland</u> M.D.				ADDRESS (Street, city or town, state) <u>3130 N 10th St Arlington, Va.</u>			
PHYSICIAN'S NAME (Type) <u>James R. McCalland</u>				DATE SIGNED <u>Nov 8 1957</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9 NOV 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bayside Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Morehead City N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lees Son - Washington D.C.</u>				24a. REC'D BY REGISTRAR <u>Nov 8 1957</u>			
24b. REGISTRAR'S SIGNATURE <u>James R. McCalland</u>							

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		MALE		35		JAN 15 1922	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
SALT LAKE CITY, UTAH		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TIME OF DEATH	
NOV 10 1957		SALT LAKE CITY, UTAH		10:00 AM		10:00 AM	
NAME OF PHYSICIAN		NAME OF HOSPITAL		NAME OF BURIAL PLACE		NAME OF FUNERAL HOME	
DR. J. H. HARRIS		SALT LAKE CITY HOSPITAL		SALT LAKE CITY CEMETERY		HARRIS FUNERAL HOME	
SIGNATURE OF PHYSICIAN		SIGNATURE OF HOSPITAL		SIGNATURE OF BURIAL PLACE		SIGNATURE OF FUNERAL HOME	
[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF CERTIFICATE		NAME OF REGISTRAR		NAME OF COUNTY CLERK		NAME OF VICE REGISTRAR	
NOV 10 1957		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. S.

NOV 8 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files.
FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12280 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12278 234

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of b. COUNTY mbia		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill		c. LENGTH OF STAY IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6980 Livingston Road S.E.			d. STREET ADDRESS 9 16th Street S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Richard Edward Swan			4. DATE OF DEATH Month Day Year November 7 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/16/38	9. AGE (In years last birthday) 19 yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Apprentice Painter Painting		10b. KIND OF BUSINESS OR INDUSTRY Painting		11. BIRTHPLACE (State or foreign country) District of Columbia U. S. A.	
13. FATHER'S NAME Edward S. Swan			14. MOTHER'S MAIDEN NAME Corine Doome		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 577-52-9318		17. INFORMANT Address Mrs Edward S. Swan Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 981x DUE TO Hemorrhage and shock Conditions, if any, which gave rise to immediate cause (b) Gun shot wound of the chest (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot while breaking into a store			
20c. TIME OF INJURY Month, Day, Year 4:10 p.m. 11/7/1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Store Oxon Hill P.G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE James I. Boyd			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) James I. Boyd			DATE SIGNED 11/7/57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-12-1957		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l	
22d. LOCATION (City, town, or county) Fort Myer		22e. REC'D BY REGISTRAR NOV 12 1957		22f. REGISTRAR'S SIGNATURE Carrie Campbell	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. PLACE OF DEATH	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF MEDICAL EXAMINER		11. SIGNATURE OF WITNESS		12. SIGNATURE OF CORONER	
13. SIGNATURE OF JURY		14. SIGNATURE OF JUDGE		15. SIGNATURE OF CLERK	
16. SIGNATURE OF SHERIFF		17. SIGNATURE OF DEPUTY SHERIFF		18. SIGNATURE OF CONSTABLE	
19. SIGNATURE OF TOWN CLERK		20. SIGNATURE OF VOTING CLERK		21. SIGNATURE OF JURY CLERK	
22. SIGNATURE OF JURY CLERK		23. SIGNATURE OF JURY CLERK		24. SIGNATURE OF JURY CLERK	
25. SIGNATURE OF JURY CLERK		26. SIGNATURE OF JURY CLERK		27. SIGNATURE OF JURY CLERK	
28. SIGNATURE OF JURY CLERK		29. SIGNATURE OF JURY CLERK		30. SIGNATURE OF JURY CLERK	
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43. SIGNATURE OF JURY CLERK		44. SIGNATURE OF JURY CLERK		45. SIGNATURE OF JURY CLERK	
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49. SIGNATURE OF JURY CLERK		50. SIGNATURE OF JURY CLERK		51. SIGNATURE OF JURY CLERK	
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61. SIGNATURE OF JURY CLERK		62. SIGNATURE OF JURY CLERK		63. SIGNATURE OF JURY CLERK	
64. SIGNATURE OF JURY CLERK		65. SIGNATURE OF JURY CLERK		66. SIGNATURE OF JURY CLERK	
67. SIGNATURE OF JURY CLERK		68. SIGNATURE OF JURY CLERK		69. SIGNATURE OF JURY CLERK	
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73. SIGNATURE OF JURY CLERK		74. SIGNATURE OF JURY CLERK		75. SIGNATURE OF JURY CLERK	
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91. SIGNATURE OF JURY CLERK		92. SIGNATURE OF JURY CLERK		93. SIGNATURE OF JURY CLERK	
94. SIGNATURE OF JURY CLERK		95. SIGNATURE OF JURY CLERK		96. SIGNATURE OF JURY CLERK	
97. SIGNATURE OF JURY CLERK		98. SIGNATURE OF JURY CLERK		99. SIGNATURE OF JURY CLERK	
100. SIGNATURE OF JURY CLERK		101. SIGNATURE OF JURY CLERK		102. SIGNATURE OF JURY CLERK	

BUREAU V. 3

NOV 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12243

CERTIFICATE OF DEATH

12279

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1 day, 18½ hr. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Gen. Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) E. Riverdale 25 d. STREET ADDRESS 62 Carters Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Tabbs				4. DATE OF DEATH Month Day Year November 3 19 57			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown	
9. AGE (In years last birthday) 59 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Charlie Carter			
14. MOTHER'S MAIDEN NAME Martha ?				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.				17. INFORMANT Viola Dailey Address 2007 Md. Ave., N.E. #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetic acidosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH See Mys See Mys	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-1 , 19 57 , to 11-3 , 19 57 , that I last saw the deceased alive on 11-3 , 19 57 , and that death occurred at 3:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Ronald S. Fleischer				ADDRESS (Street, city or town, state) 5432 Ames Capital Rd			
PHYSICIAN'S NAME (Type) RONALD S FLEISCHER				DATE SIGNED 11/4/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-7-57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington + Son				ADDRESS 467 N St NW		24a. REC'D BY REGISTRAR REV 6 57	
				24b. REGISTRAR'S SIGNATURE Rev. [Signature]			

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH	
SEX		RACE	
MARRIED		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
NAME OF PHYSICIAN		NAME OF REGISTRAR	
ADDRESS OF PHYSICIAN		ADDRESS OF REGISTRAR	
CITY OF PHYSICIAN		CITY OF REGISTRAR	
STATE OF PHYSICIAN		STATE OF REGISTRAR	
ZIP CODE OF PHYSICIAN		ZIP CODE OF REGISTRAR	
FEDERAL IDENTIFICATION NUMBER		FEDERAL IDENTIFICATION NUMBER	
MAYOR'S OFFICE		MAYOR'S OFFICE	
CITY CLERK		CITY CLERK	
COUNTY CLERK		COUNTY CLERK	
STATE CLERK		STATE CLERK	
FEDERAL BUREAU OF INVESTIGATION		FEDERAL BUREAU OF INVESTIGATION	
DEPARTMENT OF JUSTICE		DEPARTMENT OF JUSTICE	
UNITED STATES OF AMERICA		UNITED STATES OF AMERICA	

RECEIVED
NOV 6 1957
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12281

CERTIFICATE OF DEATH

12284 ✓

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Temple Hills</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Temple Hills</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4818 Leslie Ave.</u>				d. STREET ADDRESS <u>4818 Leslie Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>IRENE CATHERINE TAYLOR</u>				4. DATE OF DEATH <u>11 - 11 - 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 15, 1893</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Prevost</u>				14. MOTHER'S MAIDEN NAME <u>Louisa C. Dunnington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>577-03-9778</u>		17. INFORMANT <u>Mr. Wade H. Taylor</u>		Address <u>4818 Leslie Ave Temple Hills Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>203X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Multiple Myeloma</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>2 1/2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT. 1954</u> to <u>11 - 11, 1957</u> , that I last saw the deceased alive on <u>11 - 10, 1957</u> , and that death occurred at <u>11:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. P. D'Angelo M.D.</u>				ADDRESS (Street, city or town, state) <u>4223 Silver Hill Rd. Silver Hill, Md.</u>			
PHYSICIAN'S NAME (Type) <u>J. P. D'ANGELO M.D.</u>				DATE SIGNED <u>NOV 13 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 14, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Barnabas Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Temple Hills Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO.</u>				ADDRESS <u>517 11th St. SE. Wash., D.C.</u>		24a. REC'D BY REGISTRAR <u>Carrie Campbell</u>	
				24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MAYNARD		45		M		W		1912		BALTIMORE		BALTIMORE		MD		USA	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
NOV 13 1957		10:00 AM		HOME		BALTIMORE		MD		USA		NOV 13 1957		10:00 AM		HOME	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED		DIVORCED	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED		MARRIED	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
NOV 13 1957		10:00 AM		HOME		BALTIMORE		MD		USA		NOV 13 1957		10:00 AM		HOME	

BUREAU V. 3

NOV 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12281

12282

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 1 yr. 7 mos. and 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Washington 47x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 1204 R. St., N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hattie Middle W. Last Thompson				4. DATE OF DEATH Month 11 Day 11 Year 19 57			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/20/1882		9. AGE (In years lost birthday) yrs. 75	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Charwoman		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jordan E. Williams				14. MOTHER'S MAIDEN NAME Joanna Walker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 579-16-4121		17. INFORMANT Decedent Address -	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of rectum 154x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 0025 Pulmonary tuberculosis; amebic pleuritis with effusion, right; residuals of cerebrovascular accident with right sided paresis.						INTERVAL BETWEEN ONSET AND DEATH 7 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. s. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/11, 1956, to 11/11, 1957, that I last saw the deceased alive on 11/11, 1957, and that death occurred at 7:15 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Moe Weiss M.D. Glenn Dale Hospital 11/11/57 PHYSICIAN'S NAME (Type) Moe Weiss, M. D. Glenn Dale, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-15-57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) 4600 Benning Road, N.E.	
23. FUNERAL DIRECTOR'S SIGNATURE Johnson & Perkins				ADDRESS 4804 Cal Ave. N.W.		24a. REC'D BY REGISTRAR DATE NOV 14 '57	
				24b. REGISTRAR'S SIGNATURE Dehewich			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. DATE OF DEATH</p>		<p>10. PLACE OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>		<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>		<p>15. SIGNATURE OF NEXT OF KIN</p>	
<p>16. SIGNATURE OF CLERK</p>		<p>17. SIGNATURE OF CHIEF CLERK</p>		<p>18. SIGNATURE OF ASSISTANT CLERK</p>		<p>19. SIGNATURE OF DEPUTY CLERK</p>		<p>20. SIGNATURE OF DEPUTY ASSISTANT CLERK</p>	

BUREAU V. S.

NOV 14 1957

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FOR STATE
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12283 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12282

Reg. Disl. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenarden</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Glenarden</u>	
c. LENGTH OF STAY IN 1b <u>Wyn</u>		d. STREET ADDRESS <u>Wesley St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Johnny</u> First <u>A.</u> Middle <u>Thompson</u> Last		4. DATE OF DEATH <u>Nov 10 1957</u> Month <u>Nov</u> Day <u>10</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 4 1890</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>John Ellison</u>	
14. MOTHER'S MAIDEN NAME <u>Laura Proctor</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>217-07-1863</u>		17. INFORMANT <u>Mary C. Thompson, Glenarden</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Tuberculosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>— 19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Henry A. Wise Jr</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Henry A. Wise Jr</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11/10/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11-13-57</u>		22b. DATE THEREOF <u>11-13-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Family</u>		22d. LOCATION (City, town, or county) <u>Woodmore Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington</u>		24a. REC'D BY REGISTRAR <u>11/13/57</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>		24c. REGISTRAR'S SIGNATURE <u>—</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. The designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPT
HEALTH DEPT

MARY AND STATE DEPT OF HEALTH - SECTION 11
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 8

NOV 13 1957

RECEIVED

CERTIFICATE OF DEATH

12283

Reg. Dist. No. 100

12244

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Pe Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Alton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				d. STREET ADDRESS (see birth cert.) 08X1-2			
3. NAME OF DECEASED (Type or print) Pamela Christine Thompson				4. DATE OF DEATH Nov. 28 19 57			
5. SEX Femal	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-19-57	9. AGE (In years last birthday) 10 days	IF UNDER 1 YEAR Months 10 Days 10	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William E. Thompson				14. MOTHER'S MAIDEN NAME Mary E. Butler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT John W. Thompson Bel Alton			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 756.2 PERITONITIS DUE TO (b) GANGRENE OF ILEUM Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) CONGENITAL ATRESIA, MALROTATION & VULVUS OF ILEUM DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 11-19 19 57, to 11-28 19 57 that I last saw the deceased alive on 11-28 19 57, and that death occurred at 4:45 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. L. Deitz				ADDRESS (Street, city or town, state) 5802 Baltimore Ave Hyattsville, Md. DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-30-57	22c. NAME OF CEMETERY OR CREMATORY St Thomas		22d. LOCATION (City, town, or county) (State) Chevy Chase Md			
23. FUNERAL DIRECTOR'S SIGNATURE Orchard Inc Laplata Md.				24a. REC'D BY REGISTRAR DATE 12/3/57		24b. REGISTRAR'S SIGNATURE Julia H. Casey	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and return page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

File No.

DATE OF DEATH

DECEASED

DATE OF BIRTH

SEX

PLACE OF BIRTH

AGE

CAUSE OF DEATH

1

DECEASED

DATE OF DEATH

PLACE OF BIRTH

AGE

CAUSE OF DEATH

BUREAU V. S.

DEC 6 1957

RECEIVED

12284		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		12284242	
Item 1 Film G222 11-18-57 et		CERTIFICATE OF DEATH		Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <u>1112-69th Pl. MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>KG.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntersfield</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntersfield</u> x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1112-69 Pl.</u>		d. STREET ADDRESS <u>11-12-69 Pl.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SARAH</u> First <u>ANN</u> Middle <u>Thompson</u> Last		4. DATE OF DEATH <u>11-9</u> Month <u>9</u> Day <u>1957</u> Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1881</u>	9. AGE (In years last birthday) yrs. <u>76</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Abbeville SC.</u>	
13. FATHER'S NAME <u>ENIC Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Esther Young</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>20</u>		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept.</u> , 19 <u>55</u> , to <u>Nov. 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov. 6</u> , 19 <u>57</u> , and that death occurred at _____ M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>A. M. Bradford</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>5401-4 St. N.W. 4/9/57</u>			
PHYSICIAN'S NAME (Type) <u>A. M. BRADFORD</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11-13-57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Cem</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>FRANCA'S FUNERAL</u>		ADDRESS <u>HOME RI</u>		24a. REC'D BY REGISTRAR <u>11/13/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

HARTLAND STATE DEPARTMENT OF HEALTH—BAYTOWN, N.J.

BUREAU V. S.

1957 74 ACH.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. If designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12245

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12285

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES PHILLIP VENDEMIA		4. DATE OF DEATH Month 11 Day 17 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 Nov 1942
9. AGE (In years last birthday) 15 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas J. Vendemia		14. MOTHER'S MAIDEN NAME Pauline A. Reetz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Thomas J. Vendemia		Address Same as # 2 (Father)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Progressive muscular dystrophy DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JOHN T. MALONEY, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 11/18/57	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 11/20/57	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor P.G. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. GASCH'S SONS		ADDRESS Hyattsville, Maryland	
24a. REC'D BY REGISTRAR NOV 20 '57		24b. REGISTRAR'S SIGNATURE W. H. Smith	

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BUREAU V. S.

NOV 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12285

CERTIFICATE OF DEATH

12286

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Farmville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George Co. Rest Home</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Preston</u> Middle <u>Watts</u> Last <u>Watts</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 2, 1888</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>general construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Watts</u>		14. MOTHER'S MAIDEN NAME <u>Julia Anderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Lester Mallonee, Laurel Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic myocarditis Arteriosclerosis</u> <u>4 yrs</u> (c) <u>general Arteriosclerosis</u> <u>5 chorotic</u> <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>chronic hyperthrophic Arthritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>natural cause</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1, 1953</u> , to <u>Nov 4, 1957</u> , that I last saw the deceased alive on <u>Nov 1, 1957</u> , and that death occurred at <u>730</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul C. Van Natta</u> M.D.		ADDRESS (Street, city or town, state) <u>5440 Silver Hill Rd SE Washington D.C.</u>	
DATE SIGNED <u>Nov 8 1957</u>			
PHYSICIAN'S NAME (Type) <u>PAUL C. VAN NATTA</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/5/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. Witt Carroll</u>		ADDRESS <u>Laurel Md</u>	
24a. REC'D BY REGISTRAR <u>NOV 8 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. MEDICAL HISTORY		13. PRESENT ILLNESS		14. TREATMENT		15. POST-MORTEM		16. SIGNATURE OF PHYSICIAN	
17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF CLERK		20. SIGNATURE OF JUDGE		21. SIGNATURE OF SHERIFF		22. SIGNATURE OF CORONER		23. SIGNATURE OF DEPUTY		24. SIGNATURE OF JURY	
25. SIGNATURE OF DEPUTY		26. SIGNATURE OF JURY		27. SIGNATURE OF DEPUTY		28. SIGNATURE OF JURY		29. SIGNATURE OF DEPUTY		30. SIGNATURE OF JURY		31. SIGNATURE OF DEPUTY		32. SIGNATURE OF JURY	
33. SIGNATURE OF DEPUTY		34. SIGNATURE OF JURY		35. SIGNATURE OF DEPUTY		36. SIGNATURE OF JURY		37. SIGNATURE OF DEPUTY		38. SIGNATURE OF JURY		39. SIGNATURE OF DEPUTY		40. SIGNATURE OF JURY	
41. SIGNATURE OF DEPUTY		42. SIGNATURE OF JURY		43. SIGNATURE OF DEPUTY		44. SIGNATURE OF JURY		45. SIGNATURE OF DEPUTY		46. SIGNATURE OF JURY		47. SIGNATURE OF DEPUTY		48. SIGNATURE OF JURY	
49. SIGNATURE OF DEPUTY		50. SIGNATURE OF JURY		51. SIGNATURE OF DEPUTY		52. SIGNATURE OF JURY		53. SIGNATURE OF DEPUTY		54. SIGNATURE OF JURY		55. SIGNATURE OF DEPUTY		56. SIGNATURE OF JURY	
57. SIGNATURE OF DEPUTY		58. SIGNATURE OF JURY		59. SIGNATURE OF DEPUTY		60. SIGNATURE OF JURY		61. SIGNATURE OF DEPUTY		62. SIGNATURE OF JURY		63. SIGNATURE OF DEPUTY		64. SIGNATURE OF JURY	
65. SIGNATURE OF DEPUTY		66. SIGNATURE OF JURY		67. SIGNATURE OF DEPUTY		68. SIGNATURE OF JURY		69. SIGNATURE OF DEPUTY		70. SIGNATURE OF JURY		71. SIGNATURE OF DEPUTY		72. SIGNATURE OF JURY	
73. SIGNATURE OF DEPUTY		74. SIGNATURE OF JURY		75. SIGNATURE OF DEPUTY		76. SIGNATURE OF JURY		77. SIGNATURE OF DEPUTY		78. SIGNATURE OF JURY		79. SIGNATURE OF DEPUTY		80. SIGNATURE OF JURY	
81. SIGNATURE OF DEPUTY		82. SIGNATURE OF JURY		83. SIGNATURE OF DEPUTY		84. SIGNATURE OF JURY		85. SIGNATURE OF DEPUTY		86. SIGNATURE OF JURY		87. SIGNATURE OF DEPUTY		88. SIGNATURE OF JURY	
89. SIGNATURE OF DEPUTY		90. SIGNATURE OF JURY		91. SIGNATURE OF DEPUTY		92. SIGNATURE OF JURY		93. SIGNATURE OF DEPUTY		94. SIGNATURE OF JURY		95. SIGNATURE OF DEPUTY		96. SIGNATURE OF JURY	
97. SIGNATURE OF DEPUTY		98. SIGNATURE OF JURY		99. SIGNATURE OF DEPUTY		100. SIGNATURE OF JURY		101. SIGNATURE OF DEPUTY		102. SIGNATURE OF JURY		103. SIGNATURE OF DEPUTY		104. SIGNATURE OF JURY	
105. SIGNATURE OF DEPUTY		106. SIGNATURE OF JURY		107. SIGNATURE OF DEPUTY		108. SIGNATURE OF JURY		109. SIGNATURE OF DEPUTY		110. SIGNATURE OF JURY		111. SIGNATURE OF DEPUTY		112. SIGNATURE OF JURY	
113. SIGNATURE OF DEPUTY		114. SIGNATURE OF JURY		115. SIGNATURE OF DEPUTY		116. SIGNATURE OF JURY		117. SIGNATURE OF DEPUTY		118. SIGNATURE OF JURY		119. SIGNATURE OF DEPUTY		120. SIGNATURE OF JURY	
121. SIGNATURE OF DEPUTY		122. SIGNATURE OF JURY		123. SIGNATURE OF DEPUTY		124. SIGNATURE OF JURY		125. SIGNATURE OF DEPUTY		126. SIGNATURE OF JURY		127. SIGNATURE OF DEPUTY		128. SIGNATURE OF JURY	
129. SIGNATURE OF DEPUTY		130. SIGNATURE OF JURY		131. SIGNATURE OF DEPUTY		132. SIGNATURE OF JURY		133. SIGNATURE OF DEPUTY		134. SIGNATURE OF JURY		135. SIGNATURE OF DEPUTY		136. SIGNATURE OF JURY	
137. SIGNATURE OF DEPUTY		138. SIGNATURE OF JURY		139. SIGNATURE OF DEPUTY		140. SIGNATURE OF JURY		141. SIGNATURE OF DEPUTY		142. SIGNATURE OF JURY		143. SIGNATURE OF DEPUTY		144. SIGNATURE OF JURY	
145. SIGNATURE OF DEPUTY		146. SIGNATURE OF JURY		147. SIGNATURE OF DEPUTY		148. SIGNATURE OF JURY		149. SIGNATURE OF DEPUTY		150. SIGNATURE OF JURY		151. SIGNATURE OF DEPUTY		152. SIGNATURE OF JURY	
153. SIGNATURE OF DEPUTY		154. SIGNATURE OF JURY		155. SIGNATURE OF DEPUTY		156. SIGNATURE OF JURY		157. SIGNATURE OF DEPUTY		158. SIGNATURE OF JURY		159. SIGNATURE OF DEPUTY		160. SIGNATURE OF JURY	
161. SIGNATURE OF DEPUTY		162. SIGNATURE OF JURY		163. SIGNATURE OF DEPUTY		164. SIGNATURE OF JURY		165. SIGNATURE OF DEPUTY		166. SIGNATURE OF JURY		167. SIGNATURE OF DEPUTY		168. SIGNATURE OF JURY	
169. SIGNATURE OF DEPUTY		170. SIGNATURE OF JURY		171. SIGNATURE OF DEPUTY		172. SIGNATURE OF JURY		173. SIGNATURE OF DEPUTY		174. SIGNATURE OF JURY		175. SIGNATURE OF DEPUTY		176. SIGNATURE OF JURY	
177. SIGNATURE OF DEPUTY		178. SIGNATURE OF JURY		179. SIGNATURE OF DEPUTY		180. SIGNATURE OF JURY		181. SIGNATURE OF DEPUTY		182. SIGNATURE OF JURY		183. SIGNATURE OF DEPUTY		184. SIGNATURE OF JURY	
185. SIGNATURE OF DEPUTY		186. SIGNATURE OF JURY		187. SIGNATURE OF DEPUTY		188. SIGNATURE OF JURY		189. SIGNATURE OF DEPUTY		190. SIGNATURE OF JURY		191. SIGNATURE OF DEPUTY		192. SIGNATURE OF JURY	
193. SIGNATURE OF DEPUTY		194. SIGNATURE OF JURY		195. SIGNATURE OF DEPUTY		196. SIGNATURE OF JURY		197. SIGNATURE OF DEPUTY		198. SIGNATURE OF JURY		199. SIGNATURE OF DEPUTY		200. SIGNATURE OF JURY	

ORIGINAL FILED IN

BUREAU V. S.

NOV 8 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12287

12286

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u>		c. LENGTH OF STAY IN TB <u>17 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 District Heights</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7205-Elmhurst Street</u>				d. STREET ADDRESS <u>7205 Elmhurst St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Maud</u> Middle <u>Gertrude</u> Last <u>Weedon</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>28</u> Year <u>1957</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 15, 1884</u>			
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>									
13. FATHER'S NAME <u>Robert Raley</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Bender</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u> </u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Rupture of the heart</u> (c) <u> </u> DUE TO (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>James T. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>James T. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/23/57</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Congressional</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 25 57</u> DATE		24b. REGISTRAR'S SIGNATURE <u> </u>			

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1957 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 31

NOV 26 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

12246

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12288

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) LeLand Memorial Hospital				d. STREET ADDRESS 9017 50th Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eileen First Denise Middle West Last				4. DATE OF DEATH Month 11- Day 7- Year 19 57			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-25-1954	
9. AGE (In years last birthday) 3 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *****		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Claude Raymond West				14. MOTHER'S MAIDEN NAME Gloria Dean Wise			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 0		16. SOCIAL SECURITY NO. 0		17. INFORMANT Claude R. West; same as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia DUE TO Conditions, if any, which gave rise to the immediate cause (a), stating the underlying cause last. (b) Congestive heart failure DUE TO (c) Terminal pneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> November 7, 1957			
22a. BURIAL, CREMATION, REBURYAL (Specify) Burial		22b. DATE THEREOF Nov 12, 1957		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24. REC'D BY REGISTRAR NOV 12 1957 24b. REGISTRAR'S SIGNATURE James Leroy			

RECEIVED STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

2222

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		35		11-10-57	
Place of Birth		Race		Occupation		Cause of Death	
New York City		Caucasian		Teacher		Heart Disease	
Date of Admission		Date of Discharge		Date of Death		Time of Death	
11-05-57		11-08-57		11-10-57		10:00 PM	
Place of Death		Place of Burial		Name of Physician		Signature of Physician	
Home		Cemetery		Dr. Smith		[Signature]	
Manner of Death		Signature of Medical Examiner		Date of Examination		Time of Examination	
Natural		[Signature]		11-12-57		10:00 AM	
Signature of Medical Examiner		Date of Examination		Time of Examination		Signature of Coroner	
[Signature]		11-12-57		10:00 AM		[Signature]	

BUREAU V. 5

NOV 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12247 CERTIFICATE OF DEATH

12289

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>20 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Whitmer</u> Last				4. DATE OF DEATH Month <u>Nov.</u> Day <u>1</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>17 April 1871</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Jacob Lonas</u>		14. MOTHER'S MAIDEN NAME <u>Christina Walters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>577-48-5325</u>		17. INFORMANT <u>Nellie Ballentine,</u>		Address <u>Temple Hill Washington, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas with</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Metastases</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Oct 12</u> , 19 <u>57</u> , to <u>Nov 1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 31</u> , 19 <u>57</u> , and that death occurred at <u>7:20A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Quora G. Lean</u>				DATE SIGNED <u>11-1-57</u>			
PHYSICIAN'S NAME (Type) <u>Hyattsville, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-3-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Jackson</u>		22d. LOCATION (City, town, or county) (State) <u>Mount Jackson Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS <u>Woodstock, Va.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 7 57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Quora G. Lean</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. MEDICAL HISTORY	
10. HISTORY OF PRESENT ILLNESS		11. PHYSICAL EXAMINATION		12. LABORATORY EXAMINATIONS	
13. POSTMORTEM EXAMINATION		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF CORONER		18. SIGNATURE OF JURY	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN		21. SIGNATURE OF BURIAL SOCIETY	
22. SIGNATURE OF FUNERAL HOME		23. SIGNATURE OF CEMETERY		24. SIGNATURE OF INTERMENT	
25. SIGNATURE OF BURIAL		26. SIGNATURE OF CREMATION		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
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52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
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61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
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85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

BUREAU V. 2

NOV 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 12248 122290 12248 CERTIFICATE OF DEATH Reg. Dist. No. 122290

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>P.B.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly Md.</u>				c. LENGTH OF STAY IN 1b <u>54 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Hillside Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u>				d. STREET ADDRESS <u>1221 56th Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Catherine Wicker</u>				4. DATE OF DEATH Month Day Year <u>Nov 5 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-28-92</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Frank Cross</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Trapp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Dollie Wicker</u>		Address <u>1221 56th Ave Hillside, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic heart disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. ft. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>11/1/57</u> , 19 <u>57</u> , to <u>11/5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/5</u> , 19 <u>57</u> , and that death occurred at <u>11:05 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John T. Lynn</u>				M.D. <u>524 St. Barnabas Rd Wash 21 D.C.</u>			
PHYSICIAN'S NAME (Type) <u>John T. Lynn</u>				ADDRESS (Street, city or town, state) <u>524 St. Barnabas Rd Wash 21 D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-9-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Addison Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Seat Pleasant, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Mattingly</u>				ADDRESS <u>131-11 St. S. E. Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 8 '57</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12291

1. PLACE OF DEATH o. COUNTY <u>2505 CHEVERLY AVE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PG.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY MD.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 CHEVERLY MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RESIDENCE</u>		d. STREET ADDRESS <u>12805 CHEVERLY AVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Louise E. Wilson</u>		4. DATE OF DEATH Month Day Year <u>11-9 57 19</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-9-1898</u>
9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>LONDON ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Mrs THEENY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Edward H Wilson - Son - Nurse</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ESSENTIAL HYPERTENSION - 5 YRS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 MIN</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12 JAN., 1954</u> , to <u>8 NOV., 1957</u> , that I last saw the deceased alive on <u>8 Nov., 1957</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Kehoe</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>CHEVERLY, MD 8 Nov 1957</u>	
PHYSICIAN'S NAME (Type) <u>JOHN KEHOE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-12-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Leonard</u>	22d. LOCATION (City, town, or county) (State) <u>Culmer Manor MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home Wash, DC</u>		ADDRESS <u>12805 CHEVERLY AVE</u>	
24a. REC'D BY REGISTRAR <u>Rebecca</u>		24b. REGISTRAR'S SIGNATURE <u>Rebecca</u>	
DATE <u>NOV 13 57</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BUREAU V. S.

NOV 13 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 3 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4707 - Banner street		e. STREET ADDRESS 4707 - Banner street	
3. NAME OF DECEASED (Type or print) Louis Allen Wisooker		4. DATE OF DEATH Month November Day 20 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/29/1894
9. AGE (In years last birthday) yrs. 63		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cleaner Foreman	
10b. KIND OF BUSINESS OR INDUSTRY Md. University		11. BIRTHPLACE (State or foreign country) Warsaw, Russia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Max Wisooker	
14. MOTHER'S MAIDEN NAME Rose Shepherd		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. 1(579-10-8520)		17. INFORMANT Nellie Mae Wisooker (Same as above)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic Heart Disease DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 day ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July , 19 56 , to Nov 20 , 19 57 , that I last saw the deceased alive on Nov 20 , 19 57 , and that death occurred at 3:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William D. Rosson MD M.D.		ADDRESS (Street, city or town, state) 5304 ANNAPOLIS ROAD	
PHYSICIAN'S NAME (Type) WILLIAM D. ROSSON, MD.		DATE SIGNED BLADENSBURG, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/22/57	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home Inc. not Rainier, Md.		24a. REC'D BY REGISTRAR NOV 25 1957	
24b. REGISTRAR'S SIGNATURE James Henry			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12250

Item 14 Film G222 11-20-57 et

CERTIFICATE OF DEATH

12293

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly				c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Wash. DC 27	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS 15 66th St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Wrighton Last Wrighton				4. DATE OF DEATH Month November Day 10 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 30, 1877	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 80 Days 19 Hours 57 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Wilcox		14. MOTHER'S MAIDEN NAME Ruth Hayden Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Ruth Hayden		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarct 420.0 DUE TO Accl. and dec. heart. Left cor. Arh Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Arterio Sclerotic Heart Disease (c) Arterio Sclerotic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 9, 1957 , to Nov. 10, 1957 , that I last saw the deceased alive on Nov. 9, 1957 , and that death occurred at 6 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Arnold A. Leach				ADDRESS (Street, city or town, state) 805 Sheridan St Hyattsville Md.		DATE SIGNED 11-11-57	
PHYSICIAN'S NAME (Type) ARNOLD A. LEACH M.D. Hyattsville Md							
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 11/13/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gasch				ADDRESS 4739 Balto. Ave. Hyattsville, Md.		24. REC'D BY REGISTRAR NOV 15 '57	
				24b. REGISTRAR'S SIGNATURE Gasch			

ANNULAR STATE DEPARTMENT OF HEALTH-BALTIMORE 18
 CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE		ALABAMA		UNITED STATES			
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		SPECIAL OCCASION			
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		CLOCK REPAIRER					
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
APR 4 1968		MEMPHIS		SHOOTING		SUICIDE		100-4438861							
TIME OF DEATH		TEMPERATURE		PULSE		BLOOD PRESSURE		RESPIRATIONS		SIGNS OF LIFE		POSTMORTEM		OTHER	
10:00 AM		98.6		60		120/80		18		YES		NO		NO	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF OFFICIAL	

BUREAU V. 8

NOV 15 1957

RECEIVED

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
 DATE 11-15-2010 BY 60322 UCBAW/STP

12287

CERTIFICATE OF DEATH

Reg. Dist. No. 12294

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wildercroft				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Wildercroft			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6700 Auburn Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ANNA ELIZABETH YOUNG				4. DATE OF DEATH Month Day Year November 22nd, 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27th, 1877	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Myersville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Melvin Leatherman				14. MOTHER'S MAIDEN NAME Martha Ellen Grossnichel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address John M. Young 2012 Ridge Pl. S.E. Wash. D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Cerebral Accident DUE TO (b) Hypertension Heart Disease DUE TO (c) 8 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 2, 1949 to Nov. 11, 1957 that I last saw the deceased alive on Nov. 11, 1957, and that death occurred at 11:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED M.D. 4314 GALLATIN ST. 11-22-57 ACTUAL SIGNATURE AARON DEITZ, M.D. HYATTS, MD. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/25/1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery Colmar Manor, Pr. Geo. Co. Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR DATE NOV 26 57		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES EARL RAY		Male		35		White		April 24, 1928		Memphis, Tennessee		April 4, 1968		Memphis, Tennessee		Suicide		Homicide		JAMES EARL RAY		JAMES EARL RAY	
13. OCCUPATION		14. EDUCATION		15. MARITAL STATUS		16. RELIGION		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
Attorney		High School		Single		Methodist		None		None		None		None		None		None		None		None	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

RECEIVED
BUREAU V. S.
NOV 28 1967

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. The designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12295

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1/2 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Cheverly	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 6000 State Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Henry Middle Oscar Last Zorn			4. DATE OF DEATH Month November Day 21 Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-10-04		9. AGE (in years last birthday) 53 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier and paymaster		10b. KIND OF BUSINESS OR INDUSTRY Ambassador Hotel		11. BIRTHPLACE (State or foreign country) Switzerland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME xxxx Henry O. Zorn			14. MOTHER'S MAIDEN NAME (Lucille) (Georgous) Lucy Gorgeous		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-01-8841		17. INFORMANT Elisa Zorn; same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 976x DUE TO Conditions, if any, which gave rise to immediate cause (b) Gunshot wound of head (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted wound with .22 cal. rifle.			
20c. TIME OF INJURY Month, Day, Year 8.40 11-20-57 Hour XX p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Cheverly		20g. (County) Pr. Geo.		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		November 21, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/25/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
22d. LOCATION (City, town, or county) Prince Georges County, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St., N.W.		ADDRESS Wash. D. C.		24a. REC'D BY REGISTRAR NOV 26 57	
24b. REGISTRAR'S SIGNATURE					

STATE
DEPT.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Trinity George	
Sex		Male	
Age		1 day	
Date of Birth		November 11, 1956	
Place of Birth		New York City	
Usual Residence		600 State Street	
Cause of Death		Sudden death	
Place of Death		Home	
Time of Death		11:00 AM	
Signature of Physician		[Signature]	
Signature of Medical Examiner		[Signature]	

Self-inflicted wound with .38 cal. rifle.

BUREAU V. 2

NOV 26 1957

RECEIVED

Date of Death		11-20-57	
Place of Death		Home	
Cause of Death		Self-inflicted wound with .38 cal. rifle.	
Place of Death		Home	
Time of Death		11:00 AM	
Signature of Physician		[Signature]	
Signature of Medical Examiner		[Signature]	